Exhibit 39

IN THE DISTRICT OF MASSACHUSETTS

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IN RE:	:	
PHARMACEUTICAL INDUSTRY		MDL No. 1456
AVERAGE WHOLESALE PRICE	:	01-CV-1225
LITIGATION		

30(b)(6) DEPOSITION OF: IHC HEALTH PLANS

ERIC CANNON

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Place:	IHC Health Plans
	4646 West Lake Park Blvd.
	Salt Lake City, Utah 84120
Date:	September 13, 2004
	9:40 a.m.
Reporter:	Vickie Larsen, CSR/RPR

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September 13, 2004 9:40 a.m.

PROCEEDINGS

ERIC CANNON,
called as a witness, having been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. EVERETT:

Q. Would you please state your name and current position for the record.

A. My name is Eric Cannon. I am Director of Pharmacy Services for IHC Health Plans.

Q. Mr. Cannon, have you been deposed before?

A. No.

Q. Let me just run through some of the basics of the deposition.

First of all, as I'm sure you realize now, you are under oath. So it's just like you're in a courtroom. Do you understand that?

A. Yes.

Q. And because there is a court reporter here who's taking down everything that's said, it's important that you wait until I finish my question before answering.

A. Okay.

Q. Do you understand?

And that you speak out loud. The court reporter can't take down head nods.

A. Yes.

Q. If you don't understand anything in any of my questions, feel free to ask me to clarify. I'm happy to do that.

A. Okay.

Q. And if you need to take a break, let me know and I'm happy to do that as well, as long as there's not a question that is pending.

A. Okay.

MR. LAWLOR: Clay, then just for purposes of the protective order, we'd like to consider everything that Eric says here highly confidential.

MR. EVERETT: Okay.

Q. Mr. Cannon, you understand that you're

here today testifying on behalf of IHC Health Plans?

A. Yes.

Q. And that my questions today will go to the knowledge of the company, unless I indicate that I'm asking for your personal knowledge. Do you understand that?

A. Yes.

Q. Okay. I'm going to hand you what I'm marking as IHC Deposition Exhibit 1.

(Exhibit Cannon 001 was marked for identification.)

Q. BY MR. EVERETT: Which is the Amended Notice of Deposition of IHC Health Plan that was sent out last week. Are you familiar with this document?

A. I have seen it before.

Q. On Pages 3 through 6 of the document are a list of deposition subjects. Have you seen these deposition subjects before?

A. Yes, I have.

Q. Are you prepared today to testify about IHC Health Plans' knowledge with regard to each of these deposition items?

A. Yes, I am.

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Q. Are you the person at IHC Health Plans, Inc. that is most knowledgeable about each of these subjects?
A. Yes.
Q. Okay. By way of background, would you please describe for me your education after high school.
A. After high school I spent approximately three years working on undergraduate work at the University of Utah, at which time I transferred to Idaho State University where I worked on and completed my Doctorate of Pharmacy Degree.
Q. Have you taken any -- any other courses after receiving your Doctorate of Pharmacy Degree?
A. Formal courses through the universities, no.
Q. Okay. After graduating from Idaho State what was the first job that you held?
A. The first job I held I worked as a retail pharmacist.
Q. For what company?
A. Holiday Pharmacy.

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Q. Where is that located?
A. Salt Lake City.
Q. And what were your responsibilities?
A. I worked as a staff pharmacist doing the dispensing of prescriptions. I had responsibility to work on contracts with managed care companies. Also worked on business with assisted living facilities and nursing homes.
Q. What year did you begin that?
A. 1993.
Q. Okay. And while you were in that position did you have occasion to learn the prices paid by Holiday Pharmacy for pharmaceutical products?
A. Yes, I did.
Q. Okay. Were you involved at all in the purchase of pharmaceutical products for Holiday Pharmacy?
A. Yes, I was.
Q. And what did your duties with regard to the purchase of pharmaceutical products involve?
A. It involved purchasing either from a wholesaler or directly from an intermediary in the

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cases of generic drugs, or directly from the manufacturers products that we would use on a daily basis to dispense prescription store clientele.
Q. How large is Holiday Pharmacy?
A. In terms of volume of prescriptions? Square footage of the store?
Q. Fair question. In terms of volume of prescriptions.
A. We did, on average, 300 to 500 prescriptions a day.
Q. In your position as a retail pharmacist for Holiday Pharmacy were you able to negotiate discounts off of list prices for pharmaceutical products purchased?
A. List price. Define list price.
Q. Well, in the context of pharmaceutical products what do you understand the term "list price" to mean?
A. I would assume list price to be the acquisition price, listed wholesale acquisition cost, or in the case of generics that may vary widely. So in terms of purchasing products from the wholesaler

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there was no opportunity to negotiate off of list price. In terms of direct manufacturer contracts there would be, at times, opportunities to purchase products at a reduced price.
In terms of generics, we would often be contacted by intermediaries that would have prices greatly reduced from what you could purchase them, say through a wholesaler.
Q. Okay. Which intermediaries did you deal with for generic products?
A. I cannot recall.
Q. Okay. Did you negotiate any charge back contracts with manufacturers?
A. As in rebate discounts or -- no.
Q. Okay. You mentioned before that you understood list price in the context of purchases by pharmacies to equate generally to wholesale acquisition cost; is that correct?
A. Yes.
Q. And is that also known as WAC?
A. Yes.
Q. In general what was the relationship

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between the prices at which Holiday Pharmacy was able to purchase pharmaceutical products and WAC?

A. I don't know, quite honestly. I don't know that I -- we ever did a comparison between WAC per se from the standpoint of how we look at databases today and say this is AWP price, this is WAC price. It just, you know, you kind of knew what a good price was.

Q. And what is -- what was a good price?

A. It would depend by product and market factors. It would depend if product was in short supply. Would depend on the dating of the product. If a product was going to expire in six months or 12 months you may be able -- you had a shorter period of time in which that product could be sold and utilized by a patient. You had to be able to drive that volume and get rid of that product quickly. All of those things affected the price you could purchase.

Q. How long did you work for Holiday Pharmacy?

A. I worked for Holiday Pharmacy until August of 1997.

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Q. Did you hold the same position at Holiday Pharmacy the entire period?

A. Yes, I did.

Q. What was your next job?

A. I then took a position in November of 1997 with IHC Health Plans as pharmacy utilization coordinator.

Q. What were your duties as pharmacy utilization coordinator?

A. I would assist in the review and evaluation of products used by IHC Health Plans' members. I would make recommendations to the Pharmacy Therapeutics Committee on formulary decisions. I worked closely with our PBM on how products were set up in the system, whether they were set up to pay as formulary or non-formulary. Whether they had a prior authorization. I would help resolve member issues and initiate prior authorizations.

Q. Okay. What were your duties with regard to recommendations regarding formularies?

A. With regard to formulary decisions my responsibilities included the clinical evaluation of

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products within a therapeutic category or for a therapeutic use. We would look at utilization patterns, prescribing patterns by physicians. We looked at available discounts from manufacturers, how that would impact net cost. We looked at detailing and marketing efforts by manufacturers as to how utilization was being driven in one direction or another.

We would look at benefit design as to whether a category was covered under current relationships with employers. Is this a product that would be used in excluded categories, such as weight loss. That's about it.

Q. Okay.

A. And then we'd make recommendations to the P&T committee.

Q. How did utilization patterns enter into the analysis of creating a formula?

A. Utilization patterns would enter into formulary decisions in that a product may be sold or marketed by the pharmaceutical company as a once a day product, may have an approved dosage as 20 milligrams.

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Yet in clinical practice the drug needs to be used twice a day or a dose -- the recommended dose may be 20, but physicians can't get the clinical effect they want at 20 milligrams. They need to go to 40 milligrams.

And then looking at other products where instead of having to use two capsules a day or two tablets a day you could use one tablet a day.

Q. I see. And that analysis of utilization patterns would affect the treatment of different drugs on the formulary; is that correct?

A. Yes, it would.

Q. You mentioned discounts from manufacturers were one thing that was considered in making formulary decisions; is that correct?

A. Yes.

Q. How did those discounts enter into the analysis?

A. Discounts would be evaluated based on, first of all, how the discount was structured. Was it a flat discount? Did we receive a flat discount regardless of utilization? Was that discount

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structured as part of a therapeutic market basket? Did we have -- how many drugs were in that market basket? What percentage share of that market basket would we have to obtain in order to receive the discount? Was the discount structure with an up front discount and then a performance discount based on increase and use of a product?

If you can dream it, we had to evaluate it.

Q. And how did you find out about these discounts?

A. That took place during negotiations with the manufacturers.

Q. So IHC Health Plans negotiated directly with manufacturers?

A. Yes.

Q. And those negotiations took place back in 1997?

A. Yes, they did.

Q. To your knowledge did IHC Health Plans negotiate directly with manufacturers for discounts prior to 1997?

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A. Yes, they did.

Q. Do you know when IHC Health Plans began to negotiate with manufacturers for discounts?

A. I do not know the exact date. To the best of my recollection it would have taken place as early as 1993, '94.

Q. Prior to 1993 or '94 when IHC Health Plans began directly negotiating with manufacturers, how was the process for formulary decision making different?

A. I'm unaware of how that took place prior to 1993.

Q. Okay. You mentioned that therapeutic market baskets were taken into account in making decisions about discounts. What do you mean by "therapeutic market baskets"?

A. Market basket or therapeutic market basket may be, if I, for example, want to treat high cholesterol. That therapeutic market basket may include all drugs that would be considered in the statin category.

It could go beyond that category to

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include other products that would inhibit the absorption of cholesterol or may speed the elimination of cholesterol.

So depending on how that market basket is defined to include as few as three or four drugs and as many as ten or 15 drugs.

Q. And how did the definition of the therapeutic market basket in each case affect your formula decisions?

A. If the market basket was defined as being very broad with many products in it and the market share required for a particular product was required to be very high, that would make achieving those discounts more difficult and would factor into the evaluation to say how realistic is it that we could attain this market share given this market basket.

Q. Okay. How long did you hold the position of pharmacy utilization coordinator?

A. I don't know. I was pharmacy utilization coordinator up until sometime in I think 1999, at which time my title changed to manager of pharmacy services, which coincided more specifically with our

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bringing many of the PBM functions that were then being performed by Medco in house. Which increased my responsibilities as to operations, contract negotiation with pharmacies, claims processing, system setup responsibilities.

Q. Okay. Stepping back to your duties as pharmacy utilization coordinator. To whom did you report?

A. I reported to Christina Heiner.

Q. What was her title?

A. Director of pharmacy services.

Q. How many people reported to you?

A. Between 1997 and when I became manager of pharmacy services, none.

Q. And how many people reported directly to Ms. Heiner?

A. One.

Q. And that would be you?

A. That would be.

Q. All right. In 1999 you became manager of pharmacy services. You mentioned that your responsibilities increased for operations?

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A. Yes.
Q. What do you mean by "operations"?
A. Operations would be setting up the system. We had to hire one person to set up the pharmacy system within the claim system. Our claims would adjudicate the rules of adjudication.

We had to hire one person to help set up the pharmacy network in the claims system. We hired four people to take incoming phone calls from pharmacies and physicians. We had an additional staff of initially probably six to eight people that took phone calls from members.

We also had -- IHC had a pharmacy call center that was in place in 19 -- started in 1996, roughly -- that may not be accurate -- but that call center included a pharmacist and some technicians that contacted members or physicians to switch products to formulary products or preferred products. That was brought in to be included in the internal PBM within IHC.

Q. What do you understand the functions of a PBM to be?

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A. The functions of the PBM, as I understand them, would include and can include all -- encompassing all aspects of managing a pharmacy benefit or as few responsibilities as simply an intermediary that processes claims.
Q. And in soliciting contracts from PBMs can a managed care entity like IHC Health Plans choose the functions that it wants an outside PBM to perform?
A. Yes.
Q. And is there, in your opinion, strong competition among external PBMs?
A. In my opinion, yes, there is strong competition between external pharmacy benefits managers.
Q. And was that true in 1997?
A. Yes, it was.
Q. Is it still true today?
A. Yes, it is.
Q. So in 1999 you changed positions and expanded your responsibilities. To whom did you report in 1999 when you were manager of pharmacy services?

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A. Christina Heiner.
Q. Were you still her only direct report?
A. In 1999, roughly thereabouts, contracting responsibilities also resided with IHC Corporate Pharmacy Services. And those contracting coordinators -- at the time there was one contracting coordinator -- then started to report into the health plan. And so as I recall Christina had two direct reports in 1999. Myself and our contract coordinator.
Q. What is IHC Corporate Pharmacy Services?
A. IHC Corporate Pharmacy Services is a department within the IHC corporate central office that coordinated pharmacy issues across a continuum of the IHC system. They coordinated pharmacy purchasing for, and continue to coordinate pharmacy purchasing, for our 21 hospitals, the physician clinics, clinical programs within the hospitals, formulary within the hospitals, and up until 1999 also had contracting responsibilities for IHC Health Plans.
Q. How did they coordinate the purchasing of pharmacy products?
A. Coordination of purchasing of pharmacy

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products by the central offices is done through coordination meetings with the pharmacy directors. Evaluation of products as they're available to us through Amerinet, which is our third-party buying group, hospital buying group.

Looking at and coordinating efforts through McKesson, which was then our wholesaler and is our wholesaler today. Checking to make sure the contract prices are loaded into the wholesale system. Looking at utilization patterns in the hospitals. Working directly with pharmacy directors, pharmacy staff and administrators in the hospitals.
Q. How often were there coordination meetings with pharmacy directors?
A. Monthly.
Q. Is that true for the entire period that you worked for IHC Health Plans?
A. Yes.
Q. Do you know if it was true prior to 1997?
A. Yes, I believe it was. Up until -- let me correct that.

I think the corporate pharmacy services

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group was established approximately in 1995. It would have been at that point in time that the director meetings and those meetings started to take place.

Q. Prior to 1995 what did IHC generally as a general corporate entity do to coordinate pharmacy purchasing?

A. At that time -- prior to that period coordination was done through Amerinet. The buying group IHC had one pharmacist that would work directly with the facilities to coordinate purchasing.

Q. What is Amerinet?

A. Amerinet is a buying group that combines the buying power of the hospitals and facilities within the IHC system of other health systems across the United States. By pooling the buying power they increase the volume to achieve greater discounts.

Q. How is Amerinet affiliated with IHC?

A. IHC and Amerinet -- Amerinet was established in a partnership with IHC and some other health systems. Initially I believe IHC was 50 percent shareholder in the stock of Amerinet. As time has progressed IHC now I think approximately owns only

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25 percent of Amerinet.

Q. What other health systems are partners in Amerinet currently?

A. I don't know that.

Q. Do you know approximately how many other health systems are currently partners in Amerinet?

A. No, I don't.

Q. Do you know historically who the partners in Amerinet were?

A. No, I don't.

Q. Okay. Were the discounts that were negotiated by Amerinet passed through to IHC Health Plans?

A. I don't know that.

Q. You mentioned that in the -- that one of the things that the pharmacy purchasing coordination unit did was to make clear which Amerinet products were available?

A. Yes.

Q. What did that involve?

A. It would involve from a system standpoint -- when I speak of "system," I would define that as

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facilities, physician offices, surgery centers and hospitals. They would look at, within categories of drugs, the prices of those products, the clinical use patterns of those products, and say these are the prices that are available. And after the director meeting and hospital P&T committees they would work towards selecting products that were most cost effective based on clinical evidence, safety and cost.

Q. And those coordination meetings where there was discussion of the cost of pharmaceutical products also involve -- also were attended by the director of pharmacy for IHC Health Plans; is that correct?

A. Yes.

Q. And that was true throughout the period that you worked for IHC Health Plan?

A. Yes. Now let me clarify that, in that many meetings if there were not health plan issues to be discussed a pharmacy director or health plan representative would not attend those meetings or may only attend for 30 minutes to an hour.

Q. But IHC Health Plans director of pharmacy

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would have been aware of the prices paid for pharmaceutical products by the other branches of IHC?

A. Not all pharmaceutical products, but occasionally one or two products, yes.

Q. And which one or two products would that -- not in terms of brand names but --

A. It would depend on the products discussed. You've got upwards of 50,000 drugs available in any one meeting. You may only discuss one.

Q. Okay. Aside from the meetings was there any mechanism for the director of pharmacy of IHC Health Plans to become aware of the prices paid by other branches of IHC Health Plan?

A. Up until 2002 or 2003, I'm not sure which, IHC Health Plan pharmacy and IHC corporate pharmacy services were jointly located and shared office space in downtown Salt Lake. And if you had a desire to know what the system was paying for a particular product you could ask a contract manager or someone that had the ability to look up those prices.

Q. So if you wanted to find out the pricing

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of products purchased by IHC Health Services you'd just pick up the phone or walk across the hall?
A. Yes.
Q. Okay. So you became manager of pharmacy services at some point in 1999?
A. Yes.
Q. How long did you hold that position?
A. At some point my title was changed to assistant director of pharmacy services. That was more -- no additional responsibility, just simply my personal desire. And then in late 2000 or early 2001, I'm not exactly sure, Christy Heiner left IHC and I was made director of pharmacy.
Q. How did your responsibilities change when you assumed your new position as director of the pharmacy?
A. I was then responsible for all aspects of pharmaceutical use within IHC Health Plans.
Q. Were you also responsible in that position for physician administered drugs?
A. Physician administered drugs, up until and presently -- I guess we need to divide this a

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little bit.
The responsibility of contracting directly with physicians still remains within the provider relations, provider contracting department of IHC Health Plans. In the early 2000 sometime we switched to -- prior to that period of time we had not specifically looked at the prices we were paying for pharmaceuticals, and at that point in time pharmacy services or my department became involved in setting and looking at prices that we paid in physician offices.
Q. What changed to make IHC Health Plans look more closely at the prices it was paying for prescriptions drugs at physician offices?
A. I think in the early -- late '90s, early 2000 we saw more biologic products come onto the market. We saw the cost of drugs administered in our physician's office start to rise dramatically. The number of products available to be used in a physician's office was also increasing.
It was an area that possibly could have had more time and attention devoted to it. Resources

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had not existed prior to really delve into what we were paying in opportunities to decrease cost. We became more of an entity within the corporation. The opportunities did increase to take action and look at decreasing what we pay or provide better cost effective care.
Q. So am I correct that prior to the 2000 period when you began to look more closely at the prices paid for physician administered drugs, the lack of attention was driven primarily by the fact that physician administered drugs were not a large expense of IHC Health Plans?
A. I don't know that. And I don't think that's correct in saying they were not a large part of IHC Health Plans' expense. They had not had any attention or focus placed on them.
Q. Okay. Are some physician administered drugs also sold through pharmacies?
A. Yes.
Q. And if the director of provider relations had been interested to know the prices paid by IHC Health Plans to pharmacies for those drugs, he could

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have -- he or she could have determined that information by speaking to someone from the pharmacy services?
A. Yes.
Q. Were there, to your knowledge, any such informal communications between the provider relations department and the pharmacy services department about prescription drug pricing prior to 2000?
A. Yes.
Q. How often did those types of informal discussions occur?
A. Not frequently. As I recall more times than not it would be this is what we're currently paying. Is this in line with what we should be paying? Maybe discussions like that would take place two, three times a year.
We had more discussions on claims review as a claim would come in and the price would seem as though we'd been over charged and the people administering the claims review area would then ask is this an appropriate price to pay for this prescription in this setting?

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Q. And did the prices paid to providers for prescription drugs ever changed as a result of these informal discussions?
A. Yes, they did.
Q. Are you aware of any specific examples where prices changed?
A. I cannot think of any specific examples.
Q. Were prices usually decreased as a result of the discussions?
A. As many times as prices were decreased I would imagine we also increased them. It goes both ways.
Q. Okay. In your current job as the director of pharmacy services is it important to you to keep up to date on prescription drug pricing issues?
A. Yes, it is.
Q. And what do you do to keep up to date on those issues?
A. In order to keep up to date on pricing issues we first of all load into our system on a weekly basis databases from either First Data Bank or

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Medispan that include pricing information. We talk with vendors about pricing changes, price increases. We receive from manufacturers notification when prices are raised.

We track closely the number of manufacturers that may be selling a generic product that would indicate price competition in a specific category. We monitor communications that may take place through newsletter groups or journal articles or internet or wherever information -- wherever we can find information, we'll take it.

Q. One of the things that you mentioned is that you keep track of the number of companies selling generic products?
A. Yes.
Q. Why is the number of companies selling a generic product important?
A. The number of companies selling a generic product is important to us in that as the number of companies selling a particular product increases, so does competition. Generally speaking as price or as competition increases within a category, the price

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then begins to drop.
Q. Are you familiar with the term "AWP" or "average wholesale price" in the context of prescription drugs?
A. Yes, I am.
Q. And you mentioned that you subscribe to First Data Bank and/or Medispan databases; is that correct?
A. Yes.
Q. Are AWPs published in those?
A. Yes.
Q. Are AWPs for generic products also published?
A. Yes.
Q. In your experience does the AWP for a generic product tend to decrease when additional sellers of generic products enter the market?
A. No, it does not.
MR. EVERETT: Let's go off the record.
(There was a break taken.)
MR. EVERETT: Let's go back on the record.

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Q. When we went off the record we were talking about things that you do as director of pharmacy to keep up to date on drug pricing issues. And you mentioned that you read a newsletter groups and journal articles. What newsletter groups does IHC Health Plan subscribe to or receive?
A. We receive The Pink Sheet. We get a newsletter called Generic Line. We belong to a group that provides updates on injectable pricing called R.J. Health. They provide a newsletter, the title of which I'm unaware.
Q. Okay. What other periodicals?
A. Those are the main periodicals I can think of.
Q. Okay. What is The Pink Sheet?
A. The Pink Sheet is a -- it's fairly big and I'm not sure who the publisher is -- but it provides updates on issues as they go through the FDA or other issues as it relates to pharmaceuticals.
Q. You also mentioned that you subscribe to First Data Bank and/or Medispan for the pricing. Are there any other industry pricing compendia?

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A. Blue Book is the other one I can think of.
Q. How do you choose which compendia to use for pharmaceutical pricing?
A. I don't know that there is any set method for determining which you use. When we were with Medco they used First Data Bank. For the clinical systems and pharmacy systems within our hospitals and many of the retail pharmacies they use First Data Bank.
When we switched to bring pharmacy claims processing in house, the prospective health the organization we went with for that software and service, they use Medispan. Up until recently Medispan and First Data Bank had similar ownership. I don't know that there's a lot of method to the madness of picking which one.
Q. Are there differences between them?
A. You will see slight pricing variations in AWP and WAC between the manufacturers -- or suppliers -- excuse me -- of those tables.
Q. You said "slight pricing variations."

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Can you give an estimate of the percentage variation?
A. I would guess that not more than one or two, three percent.
Q. What information is provided in the databases that you receive from First Data Bank and/or Medispan?
A. There is everything from clinical information, codes that would relate to drug interactions, safety alerts, interactions based on age of a patient. There is manufacturer information on products, so by product you know the manufacturer, you know how it is supplied, packages, package sizes. Is it in a bulk bottle? Is it unit dose?
And then you receive price information for the branded products. That is AWP and WAC. For generic prices we receive AWP, WAC, and then on some products there is an average generic price.
Q. Do you know how the average generic price is calculated?
A. I do not.
Q. How long has IHC Health Plans subscribed to First Data Bank and/or Medispan?

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A. We've had First Data Bank as long as I've been here, and would imagine that that goes back probably quite a ways in time. I can't tell you exactly. First Data Bank is used in the facility systems. First Data Bank was, and still is, used by our actuary in looking at products and names and therapeutic classes. In 1999 we also purchased Medispan because that's what we were processing our claims with.
Q. And throughout the period that IHC Health Plans subscribed to or purchased First Data Bank data did it have access to WACs?
A. Yes.
Q. Are you a member of any industry associations?
A. Yes, I am.
Q. Which ones?
A. The Academy of Managed Care Pharmacy, The American Society of Health System Pharmacists, Utah Pharmaceutical Association, and up until 1998 or 1999 the National Community Pharmacy Association.
Q. Have there been any presentations or

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discussions about AWP or average wholesale price for pharmaceutical price at any of the meetings of those associations that you've attended?
A. I can't say with any certainty.
Q. Do any of those industry associations produce periodicals or reports?
A. They all produce periodicals and reports.
Q. Do you receive all of those?
A. Yes.
Q. Do you recall if any reports or periodicals from any of those industry associations discussed AWP or average wholesale price for pharmaceutical products?
A. There is discussion occasionally in those as new products come out or focus on specific therapeutic categories is written about or are written about that, they're -- the average wholesale price of a product or products in comparison with each other will be listed. It's not uncommon to have a review of antidepressants. The drugs are listed and their average wholesale price.
Q. At any of the meetings of any of those

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industry associations have there been discussions or presentations about reimbursement methodologies utilized for pharmaceutical products?

A. Yes.

Q. Now what were the context of those presentations?

A. The context of those presentations would include reviews of savings opportunities, whether in negotiations with pharmacies, physicians or hospitals as it relates to potential discounts off of AWP.

Q. Do you recall the earliest presentation that you saw about potential savings off of AWP that was made at any of these industry associations?

A. No, I do not.

Q. All right. Let's talk a little bit about the structure of IHC now that we've touched on it a little bit already. IHC Health Plans is a managed care organization; is that correct?

A. Yes, it is.

Q. What other companies are affiliated with IHC Health Plans?

A. Under the structure of Intermountain

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Health Care there is an umbrella or parent management company. Under that is IHC Health Systems, Inc., which includes the hospitals and the physician clinics. IHC Health Plans, Inc. is a separate corporate entity under the parent umbrella company.

Q. How many hospitals are owned by IHC Health Systems, Inc.?

A. I believe it's 21, although it changes -- or has changed.

Q. How about physician clinics?

A. Exactly, I don't know. Approximately 50 plus. 55, 56.

Q. Are any of the physician clinics -- do any of the physician clinics provide oncological services?

A. Yes, they do.

Q. Are there any rheumatologists employed by IHC Health Systems, Inc.?

A. Yes, there are.

Q. In what geographic area does IHC operate?

A. It operates in Utah, primarily. We have one facility in Idaho. We had a few more facilities

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in Idaho and Wyoming. Currently the bulk of our membership and our facilities are in Utah.

Q. Does IHC Health Plans, Inc. have any members in states other than Utah and Idaho?

A. Yes, we do.

Q. Do you know which states?

A. All 50, as I understand it. Many of the companies we contract with have employees outside the state of Utah or retirees in other states.

Q. And they still receive health insurance from IHC Health Plans?

A. Yes, they do.

Q. What products are marketed by IHC Health Plans?

A. We currently have as our main products IHC Care and IHC SelectMed. We have IHCMed, which is a more limited product, smaller panel. We have IHC Direct, which is more of a PPO, POS type product.

Q. What do you mean by "PPO"?

A. That's more in the IHC Direct. You're now leaving my pharmaceutical knowledge base and going to insurance that is not good. It operates more with

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a broader panel, more discounted fee for service, more ability to go outside the network and receive benefits.

Q. Are pharmaceutical products covered in all of those plans?

A. Yes, they are.

Q. Are there differences in the way that pharmaceutical products are covered in each of the plans?

A. With respect to outpatient oral medications, no. We administer the pharmacy benefit and the formulary exactly the same across all products.

With regard to injectable products, the fee schedule is slightly higher, and I believe it's under IHC Direct. But I cannot say for sure which of those -- I believe it's IHC Direct we have one fee schedule that's slightly higher.

Q. Are there different co-pays or co-insurance that members have to pay for pharmaceutical products -- let me start over. That's not a good question.

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Do the plans have different co-pays or co-insurance for pharmaceutical products?
A. Yes, they do.
Q. Do any of the plans have co-insurance for pharmaceutical products?
A. Yes, they do.
Q. Which plans?
A. Within each plan you will have varying levels of co-insurance, co-pay. That's something that takes place at the time that IHC plan sells a product to an employer group. And as we look at that product, recommendations may be made or an employer may request a certain benefit structure or co-pay or co-insurance level.
And then we, through underwriting and actuary, evaluate that and rate the plan. The employer is the one that makes the ultimate decision on what their co-pay levels are and co-insurance levels are.
Q. So it varies by contract with an employer?
A. Yes, it does.

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Q. Roughly how many variations are there on the co-insurance or co-pay levels for pharmaceutical products?
A. Five, six hundred.
Q. Are co-pays flat co-pays or co-insurance payments for pharmaceutical products more common?
A. Presently co-pays. Co-insurance on injectable drugs is more common.
Q. Has that changed over time?
A. No.
Q. Are they different co-pays for different formulary contracts?
A. There are different co-pays for formulary products based on the differences that employers may select. Employer A may have a $15 co-pay for preferred formulary products. Employer B may have a $20 or $25 co-pay.
Q. Does IHC Health Plans create its own formularies?
A. Yes, we do.
Q. Are those formularies tiered?
A. Yes, they are.

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Q. How many tiers are there?
A. Three.
Q. What is the difference between the tiers?
A. Presently we have Tier 1 being generic products and some branded products. Tier 2 is branded products that are preferred or on formulary. Tier 3 is branded, non preferred products.
Q. Are there any products that are excluded from the formulary?
A. Yes, there are.
Q. From a reimbursement standpoint how do the tiers differ?
A. Reimbursement to a contracted pharmacy or -- the reimbursement is the same as a percent off AWP.
Q. Do the co-pays or co-insurance paid by members differ based on the tier and the formulary?
A. Yes, they do.
Q. And that, again, is decided ultimately by an employer who's purchasing the product?
A. Yes, it is.
Q. Who are IHC's main competitors? IHC Health Plans?

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A. The main competitors at IHC Health Plans is, or are, Altius Health Plans, United Health Care, Regence Blue Cross Blue Shield of Utah, Cigna, and then locally a plan called Educator's Mutual.
Q. Within the state of Utah what's the size of IHC Health Plans relative to its competitors?
A. Relative to competitors IHC Health Plans has the largest HMO population. Total membership, Regence Blue Cross Blue Shield has the most membership.
Q. In terms of total membership is IHC Health Plans the second largest managed care entity in Utah?
A. I don't know. I would say we're probably the largest managed care organization, with Regence being the largest provider of insurance.
Q. Does the size of IHC Health Plans help it to negotiate higher discounts in pharmaceutical manufacturers or wholesalers?
A. Yes, it does.
Q. In terms of marketing the products of IHC Health Plans, is it important to provide the best

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possible product for the lowest possible rate?
A. Yes, it is.
Q. And do the customers of IHC Health Plans care about the cost of the products that they purchase?
A. Products being insurance products? Yes, they do.
Q. So it's important from a competitive standpoint for IHC Health Plans to keep its cost down?
A. Yes.
Q. Is it important also to keep the -- its pharmaceutical costs down?
A. Yes.
Q. What do you do to control pharmaceutical costs?
A. We control pharmaceutical costs through contracting with providers, whether it be pharmacies, home health agencies, nursing agencies, physician offices. We keep prices down by contracting with manufacturers. We keep costs down by controlling utilization or over use of products. We try and keep costs down by controlling inappropriate use of

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pharmaceuticals.
Q. What contracts does IHC Health Plans have with pharmaceutical manufacturers?
A. We currently have contracts with all the major pharmaceutical companies on those products that we have on our preferred list.
Q. Those are contracts for rebates?
A. Yes, they are.
Q. How long has IHC Health Plans contracted directly with manufacturers for rebates?
A. Since at least 1996. I have no knowledge before that.
Q. Did it contract with manufacturers for rebates even while it had a contract with an external PBM?
A. Yes, it did.
Q. During the period of time that IHC Health Plans utilized an external PBM, did the PBM separately contract with manufacturers for rebates?
A. On the products used by our members? No.
Q. All right. That PBM is more a little later. You mentioned before that you heard of the

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term AWP or average wholesale price in the context of pharmaceutical products?
A. Yes.
Q. What do you understand that term to mean?
A. Average wholesale price or AWP, as I understand it, is a price set which is similar to -- and this is an explanation I've heard given -- suggested retail price. It is not reflective of the cost at which a pharmacy or a physician purchased the drug.
And I have heard it explained in two ways; that the manufacturer set the AWP, and I've heard manufacturers say First Data Bank and Medispan set the AWP. On average what we've seen is AWP runs approximately 21 to 22 percent higher than WAC, although that varies by manufacturer, where we have seen some manufacturers with variability down around the 17, 18 percent.
Q. You mentioned that you had heard AWP referred to at some point as suggested retail price. Do you remember the context of that conversation?
A. I think that may have been in a

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presentation somewhere. And my recollection is not clear as to where. But in the context of explaining to an employer or purchaser what does AWP mean.
Q. A presentation by someone employed by IHC?
A. And I cannot remember if it was someone employed by IHC, if it was a PBM, I -- it stuck because, you know, having worked in retail pharmacy you used AWP as kind of your benchmark of price.
Q. You mentioned that AWP bears a certain relationship to WAC; is that correct?
A. Yes.
Q. Do you have any estimate of the relationship between AWP on average and prices actually paid by pharmacies?
A. No, I do not.
Q. Is it important for you to understand the differences between AWP and actual acquisition costs of pharmacists?
A. I think it's important from my position now that I understand that AWP is not the price that a pharmacy or provider pays to acquire the drug.

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Q. Do you think it's common knowledge in the industry that AWP does not equal an average of actual acquisition cost?
A. Yes, I do.
Q. And what's the basis for that belief?
A. The basis for that belief would come from just years of experience in working with pharmacies and working in pharmacies and knowing that AWP was a number that didn't reflect what we paid.
Q. For other managed health care entities that may or may not employ persons who previously worked in pharmacies, do you believe that those -- that's a terrible question. Let me start over.
Do you believe that there's a basis for others who do not have your background working directly for pharmacies to understand that AWP does not reflect actual acquisition cost by pharmacies?
A. Yes.
Q. And what would that basis be?
A. That basis would be based on conversations I've had with benefits consultants that understand that AWP is not what pharmacies purchase

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the drug for. That would be based on conversations and presentations I have seen given by PBMs to employers that indicate that AWP is not what pharmacies purchase the drug for.
Q. Have you had any conversations with benefits consultants prior to, say, 1998 that suggested that the benefits consultants understood that AWP did not equal an average of actual acquisition cost?
A. The benefit consultants, no.
Q. The same question for PBMs?
A. Yes.
Q. How early have you seen presentations or had discussions with PBMs where it was clear that they understood that AWP does not equal an actual average of acquisition cost?
A. I've had those discussions with our PBM, Medco at the time in 1997, as I work as a retail pharmacy between 1993 and 1997 as we would negotiate contracts off of AWP. In those conversations it was clear that PBM knew that we did not purchase our product at AWP.

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Q. Does IHC Health Plans reimburse for any pharmaceutical products utilizing AWP as a benchmark?
A. Yes, we do.
Q. Why does it use AWP?
A. I don't know. AWP has been the standard benchmark within the industry as long as I've been involved. And contracts from PBMs were a discount -- initially were a discount of AWP plus a percentage, and over time that has drawn into current market rates of an AWP minus discount.
Q. When you use AWP as a benchmark for pharmaceutical reimbursement, do you nonetheless try to negotiate the lowest possible price you can get from pharmacies?
A. Yes, we do.
Q. And do you, nonetheless, negotiate the lowest possible price that you can get from providers?
A. Yes, we do.
Q. Do you believe that using AWP as a benchmark for pharmaceutical reimbursement has increased the prices that IHC Health Plans paid for pharmaceutical products over what it would have paid

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if it had not used AWP?
A. No, I did not.
Q. Does IHC Health Plans currently reimburse pharmacies for pharmaceutical products at some discount off of AWP?
A. Yes, we do.
Q. Do you believe that pharmacies, nonetheless, earn some margin on their sales of pharmaceutical products?
A. Yes, I do.
Q. Do you have any estimate of what that margin is?
A. No, I do not.
Q. Is it important for you in negotiating contracts with pharmacies to have a knowledge of the pharmacy's actual acquisition cost for pharmaceutical products?
A. It is important from the standpoint that we know how far or how deep we -- or how hard we can push in those negotiations.
Q. In typical business negotiations do you typically have an understanding of the cost structure

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of the party with whom you're negotiating?
A. We have -- in negotiations we have a ballpark -- not ballpark -- but we have an idea where they may be in that, with most wholesalers and with most brand name products. There's not a lot of purchasing difference between chain pharmacies. We assume they're all fairly close in what they can purchase products for. Independent retail pharmacists may, based on the fact they may not have the size or the volume to drive deeper discounts, but we assume that they are purchasing close to WAC.
Q. In your negotiations with pharmacies have you ever asked a pharmacy directly what they were paying for pharmaceutical products?
A. No, I have not.
Q. Would you expect the pharmacies to tell you?
A. No, I would not.
Q. In your negotiations with manufacturers have you ever asked manufacturers what they charge wholesalers for pharmacies -- for pharmaceutical products?

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A. No, I have not.
Q. Would you expect them to tell you if you asked?
A. No.
Q. And why is that?
A. I would assume that is proprietary to their business model and not relative -- relevant to my negotiations with them.
Q. Have you ever heard AWP referred to as "aint what's paid"?
A. Yes, I have.
Q. When?
A. I have no idea.
Q. Is, in your experience, AWP referred to as "aint what's paid" generally in the managed care industry?
A. I would say that the idea or the notion of what is conveyed in the meaning of "aint what you paid" is generally recognized and understood within the managed care industry.
Q. What did you understand the term "wholesale acquisition cost" or "WAC" to mean?

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A. I assume, and my understanding of wholesale acquisition cost is more of a manufacturer sales price to a pharmacy.
Q. Do you believe that WAC reflects actual prices charged?
A. No, I do not.
Q. Do you believe that WAC is higher than or lower than the actual prices charged to pharmacies in general?
A. In general I would say it is higher.
Q. Is WAC also used for generic drugs?
A. WAC -- we use WAC with generic drugs as a benchmark in looking at setting a maximum allowable cost for generic drugs.
Q. Is your understanding of the meaning of the term "WAC" different for generic drugs than it is for branded drugs?
A. No. I believe that generally WAC more accurately reflects the acquisition cost of a product than does AWP. And that holds true also with generic drugs. Possibly not to the same degree that it does with branded drugs.

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Q. Okay. What's the basis for your understanding of the meaning of the term "WAC"?
A. Just working within the pharmacy industry for -- since 1993.
Q. Did IHC Health Plans ever consider using WAC as a basis for reimbursement instead of AWP?
A. No.
Q. Do you think that using WAC instead of AWP would have changed the amount paid by IHC Health Plans?
A. No, I do not.
Q. Are you familiar with wholesalers for pharmaceutical products?
A. I'm aware they exist, yes.
Q. Who are the big wholesalers?
A. McKesson, Cardinal, Amerisource Bergen. I'm sure there's others.
Q. Do you have any understanding of the margins that wholesalers earn on their sales of pharmaceutical products?
A. No, I do not.
Q. Switch to a different term. Have you

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ever heard of the term "MAC" or "maximum allowable cost"?
A. Yes, I have.
Q. And what do you understand that term to mean?
A. Maximum allowable cost, or MAC, is a price set by a PBM, managed care organization or an insurance company to indicate the maximum cost they will pay for a particular generic product.
Q. Does IHC Health Plans use MAC for any of its pharmaceutical reimbursement?
A. Yes, we do.
Q. For what types of products?
A. It's for generic products only.
Q. I'm going to hand to you what I'm marking as IHC Exhibit 2.
(Exhibit Cannon 002 was marked for identification.)
Q. BY MR. EVERETT: Which is a document bearing the Bates Numbers IHC AWP 6 through IHC AWP 26. And just so that you and Kevin understand, we took the documents that were produced by IHC Health Plans in response to subpoena and added numbers to

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them so that they're easy reference -- for easy reference in the bottom corner of the document.
Are you familiar with IHC Exhibit 2?
A. Yes, I am.
Q. What is it?
A. This is the IHC MAC list or list of generic products and their maximum allowable cost.
Q. There's a date at the bottom in the center of the first page. Is that the date that this MAC list was created?
A. That would be the date that it was last updated or printed.
Q. Just for the record, that date is May 24th, 2004.
Is IHC Exhibit 2 a document that was created by IHC Health Plans in the ordinary course of its business?
A. Yes, it is.
Q. And was it maintained by IHC Health Plans in the ordinary course of its business?
A. Yes, it is.
Q. Okay. The far left-hand column is titled

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"GPI." What is GPI?
A. GPI is a Medispan term for generic product ID.
Q. Does it correspond to an NDC number?
A. It does or can have several NDC numbers that roll up under it. Generic product ID is a ten digit number that is first -- if you go to the far left and follow those digits across, they roll into therapeutic categories. So the 33 -- you look at the first one, 33 may indicate the therapeutic category for that product.
As you go further over you start going down into specific drugs and categories of drugs within that product. So if you look at the first number on the sheet, that's specific to Acebutolol Hydrochloride 200 milligrams. If the two digits on the end were to change, as you can see below, then you move into a different strength.
Q. Okay. About halfway down the list on the first page is an entry for acetaminophen; oxycodone hydrochloride. And under the column for "IHC MAC" there's the notation "Off MAC." Do you see that?

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A. Yes, I do.
Q. What does that mean?
A. That means that we have removed the MAC for that product and will be paying it as an AWP discount.
Q. What explains the change?
A. I cannot specifically tell you why that would have gone off MAC. The product may be in short supply. There may be production issues and pharmacies are now -- there may be only one manufacturer of the product currently and pharmacies cannot purchase at the price that was set originally, which looks to be 19 cents a tablet.
Q. And how would you find out that pharmacies can no longer purchase at the price set in the IHC Health Plans' MAC list?
A. We will receive phone calls from pharmacies saying, you're killing me. We will generally, based on the number of phone calls we receive or the amount of communication between ourselves and our contracted pharmacy network, then proceed to investigate. Is there -- is this the case?

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Can they not purchase for where we've sent the product?
Q. How often does it happen that you get telephone calls from pharmacies indicating that the MAC prices published and paid by IHC Health Plans are too low?
A. Frequently. It may be weekly, may be daily. I can't say specifically.
Q. How often are products included on IHC Health Plans' MAC list taken off MAC?
A. I would say it's infrequent that we take something off MAC. We may adjust the price based on market dynamics that are influencing the purchasing of the pharmacies.
Q. Do products taken off MAC ever get put back on the MAC list?
A. Yes, they do.
Q. So the same product may be reimbursed based on IHC Health Plans' MAC price or based on a discount off of AWP, depending on the time at which it was purchased?
A. Yes.

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Q. The fourth line from the bottom on the first page is an entry for albuterol sulfate. The old price in the far right corner is indicated to be a unit price of .349 cents?
A. Yes.
Q. The new price in the third to right column is much lower; is that correct?
A. Three cents is lower than 34 cents.
Q. What explains the large price drop?
A. I don't know.
Q. In general what would cause IHC Health Plans to lower their MAC prices?
A. Awareness that there are multiple manufacturers, that there is competition that is driving down the price, what albuterol solution, in this case, or syrup could be purchased for.
Q. And what, in general, would cause IHC Health Plans to raise its MAC price for a product?
A. Indications that the price is raised.
Q. And by indications of that the price is raised do you mean the prices to -- prices paid by pharmacies?

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A. Yes.
Q. How often is the IHC Health Plans' MAC list updated?
A. We try and update it on a quarterly basis, although based on prices going up and down we generally try not to lower prices more than once a quarter. Although if prices do go up, we will raise prices more frequently.
Q. How does IHC Health Plans determine the MAC prices that are published in it's MAC list?
A. We try and make a best guess at the actual acquisition cost of products by the pharmacies. And that will involve and entail a line by line evaluation of the products in comparison with information we may obtain from people that work for us and also work in pharmacies. Information based on an aggregate looking at WAC and average generic price in Medispan, or in discussions we may have with our colleagues at IHC Health Systems, Inc. indicating the price is dropping.
Q. Is there any particular formula that is used by IHC Health Plans to calculate MAC?

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A. No. It's a random shot in the dark.
Q. MAC is also used by other managed care organizations; is that correct?
A. Yes, it is.
Q. And other managed care organizations also reimburse for pharmaceutical -- generic pharmaceutical products based on MAC?
A. Yes.
Q. To your knowledge is there a standard formula for MAC used by managed care organizations?
A. No.
Q. Does each managed care organization come up with its own MAC prices?
A. Each managed care organization comes up with their own MAC pricing based on the arrangements they may have either with their PBM or how they process claims internally. They may like to use MAC -- the MAC of their PBM. They elect to use the MAC that's set by HCFA. It varies by plan.
Q. Why does IHC Health Plans not produce a MAC list for branded products?
A. Because the variation between AWP and

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what the pharmacies purchase, because it does not vary to the degree that it does with generic drugs, there is no need to produce a brand name MAC list.

Q. Why is there a closer relationship between prices paid by pharmacies for branded products and AWP and the -- than there is for prices paid by pharmacies for generic products?

A. Branded products face no competition for their specific chemical entity or product that they sell. Thus they're branded products with patten protection. Generic products don't enjoy the same luxury as branded products as far as competition.

Q. How do you define "generic product"?

A. I define generic product based and -- and we at IHC define it -- based on the indication given to it from Medispan or First Data Bank. Medispan or First Data Bank says it's generic, then we believe it is generic.

Q. Are any generic products sold under a brand name?

A. There are branded products that are -- there are generic products that are -- just ignore all

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that mumbling.

There are generics that are branded by their generic manufacturer. So you may have a manufacturer's particular brand of oxycontin that we talked about earlier, that may carry a manufacture. That manufacturer has branded it with its particular name.

Q. Do any products start out as branded products and then become generic products?

A. I would believe it's possible, but can't think of any examples.

Q. Okay. Have you heard of the term "usual and customary"?

A. Yes, I have.

Q. And what do you understand that term to mean?

A. Usual and customary is the charge that a pharmacy would sell a product to its cash paying customers. That would be their usual and customary charge for a particular product.

Q. Do any IHC members or beneficiaries ever pay usual and customary for pharmaceutical products

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that are dispensed by pharmacies?

A. It is possible that they do. Our contracts and adjudication logic within our claims system requires that pharmacies also submit to us their usual and customary charge for a particular prescription. We then look at the negotiated AWP discount or MAC in comparison with their usual and customary charge and pay the lesser of.

Q. In general are usual and customary charges higher than the negotiated rates that you have with pharmacies?

A. Yes.

Q. But occasionally they are lower?

A. Yes.

Q. Have you heard of the term "FUL" or "federal upper limit"?

A. Yes.

Q. What do you understand that to mean?

A. I would understand that to be the federal limit that under HCFA they are willing to pay for a product.

Q. For what types of products?

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A. My understanding was generics.

Q. Does IHC Health Plans use FUL in determining the price that it pays for any products?

A. No.

Q. Are you familiar with the term "ASP" or "average sales price" in the context of pharmaceutical products?

A. Yes, I am.

Q. And what's your understanding of the meaning of that term?

A. As I understand average sales price it is a reimbursement logic that will be incorporated as a result of the Medicare Modernization Act and will be a price set through a third-party contractor of how the human services that will then establish what the average sale price of a product is.

As I understand average sales price, manufacturers will be required to submit to the federal government what the sale price -- actual sale price of a drug to their providers or to their customers is. And that average sale price will be all inclusive of discounts, whether they're given up front

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or as rebates.
Q. To your knowledge has average sales price been utilized by any private entity for reimbursing for pharmaceutical products?
A. To my knowledge, no.
Q. Has IHC Health Plans ever considered using average sales price as a basis for its reimbursement in pharmaceutical products?
A. At this point in time, no.
Q. You mentioned previously that you had had conversations with benefits consultants; is that correct?
A. Yes.
Q. Has IHC Health Plans ever contracted the services of any benefit consultant?
A. No.
Q. Has it considered using benefits consultants in the past?
A. No.
Q. Why not?
A. As a plan we have -- and let me take some of that back, in that we have in the past contracted

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with and used Milliman U.S.A. to provide us with fee schedules from across the country. And we have used those fee schedules as provided for Milliman in setting reimbursement more on procedure and facility codes, DRG's. To my knowledge at this point we have not used any of the Milliman data to establish fee schedules around pharmaceutical products.
Q. And what context did you previously have discussions with benefits consultants about the meaning of AWP?
A. That would be in meetings that I attend that may also be attended by benefit consultants. That may be in the context of my meeting with an employer who has hired a benefits consultant to help them in their contract negotiation or RFP process for a health insurer. That may be as the benefit consultants are doing presentations, either in conjunction with pharmaceutical company or at conferences.
Q. Are benefits consultants available for hire to provide consulting advice regarding pharmaceutical benefits?

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A. Yes, they are.
Q. Are they available for hire by managed care organizations?
A. Yes, they are.
Q. Are they available for hire by employers?
A. Yes, they are.
Q. Let's take another ten-minute break, if that's all right.
A. That's fine.
(There was a break taken.)
MR. EVERETT: Back on the record.
Q. How does IHC Health Plans reimburse for pharmaceutical products sold through pharmacies?
A. For products sold through pharmacies we reimburse off an AWP minus or MAC pricing. Injectable drugs dispensed in a pharmacy fall under our injectable drug fee schedule, which is typically based on or around AWP.
Q. I guess you testified previously that you only use MAC prices for generics; is that correct?
A. Yes, we do.
Q. Are any generics reimbursed based on AWP?

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A. Yes, they are.
Q. Which generics?
A. I couldn't tell you.
Q. What leads you to reimburse pharmacies for some generic products based on AWP instead of MAC?
A. We -- products are reimbursed based off of MAC when it becomes apparent to us that there's significant price differences between AWP or WAC and what the pharmacy is purchasing the product for.
Q. How does it become apparent to you that there is a significant difference between AWP or WAC and actual acquisition cost?
A. As we track the market for generics and there become numerous manufacturers of that, we may see in a newsletter or something that an additional generic manufacturer is now going to be supplying a product through The Pink Sheet.
We may see that additional manufacturers also got approval to market a generic, and then as competition grows within that particular category for that particular drug we then know the price will drop. We may receive information from pharmacies or

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physicians that price is significantly lower.
As I'm shopping at Costco I may notice that a particular generic drug is listed on their board at a very low price. I may have physicians tell me that. I may have members tell me that. And we adjust our prices according.
Q. And IHC Health Plans reimburses for branded products at a discount off of AWP?
A. That is correct.
Q. How does IHC Health Plans determine what discount to offer off of AWP?
A. I think we try and set that discount off of AWP at whatever the market will bear, and we come to those pricing determinations through negotiations with our pharmacy partners that are contracted in our network.
Q. So there's a negotiation process associated with the prices charged by IHC Health Plans?
A. Yes, there is.
Q. And every price charged by IHC Health Plans for branded pharmaceutical products is the

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result of negotiations with pharmacies?
A. Yes.
Q. I'm going to hand to you three documents that have been marked as IHC Deposition Exhibits 3, 4 and 5.
(Exhibit Cannon 003, Exhibit Cannon 004, Exhibit Cannon 005 were marked for identification.)
Q. BY MR. EVERETT: For the record, IHC Deposition Exhibit 3 is a document bearing the Bates Numbers IHC AWP 139 through IHC AWP 152. Deposition Exhibit 4 is a document bearing the Bates Numbers IHC AWP 153 through IHC AWP 166. And IHC Deposition Exhibit 5 is a document bearing the Bates Numbers IHC AWP 167 through IHC AWP 180. Take a moment and look through those exhibits.
MR. LAWLOR: I'm wondering if -- there seems to be, on these exhibits, there seems to be a numbering issue on -- at least on these two.
MR. EVERETT: Okay.
MR. LAWLOR: I think there's 153 then 168.
MR. EVERETT: I think maybe the title

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page got reversed. Is that the case also on the ones that you have there?
THE WITNESS: No, it goes --
MR. LAWLOR: It's probably just mine then.
Q. BY MR. EVERETT: Have you had a chance to look at those three documents?
A. Yes.
Q. Are you familiar with those three documents?
A. Yes, I am.
Q. What is IHC Exhibit 3?
A. IHC Exhibit 3 is our standard contract template as used with the chain pharmacies that participate in our pharmacy network.
Q. And was that document created and maintained by IHC Health Plans in the ordinary course of its business?
A. Yes, it was.
Q. Have you used the template in IHC Deposition Exhibit 3 in any negotiations with chain pharmacies?

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A. Yes, we have.
Q. Has IHC Health Plans entered into any contracts using the terms of IHC Exhibit 3?
A. Yes, we have.
Q. All right. Are you familiar with the document that has been marked as IHC Exhibit 4?
A. Yes, I am.
Q. And what is that document?
A. That is the document we use with independent pharmacies or pharmacies that are owned by a sole proprietor that are not affiliated with other pharmacies.
Q. Okay. And the same question: Is IHC Exhibit 4 a document that was created and maintained by IHC Health Plans in the ordinary course of its business?
A. Yes.
Q. And has IHC Health Plans used that contract template in its negotiations with any independent pharmacies?
A. Yes, we have.
Q. Has IHC Health Plans entered into any

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contracts with the terms that are set out in IHC Deposition Exhibit 4?
A. Yes, we have.
Q. IHC Deposition Exhibit 5. Are you familiar with that document?
A. Yes, I am.
Q. And what is that?
A. That's the contract template used with rural pharmacies.
Q. Is IHC Deposition Exhibit 5 a document that was created and maintained by IHC health plans in the ordinary course of its business?
A. Yes.
Q. Has IHC Health Plans entered into any contracts with rural pharmacies having the terms that are set out in IHC Deposition Exhibit 5?
A. Yes.
Q. When were these contract templates created?
A. These were created in 1999. At that time we were bringing pharmacy benefit management services in house. We would no longer be using the pharmacy

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network that had been contracted by Medco.
Q. Are these templates still used in negotiations with pharmacies?
A. Yes, they are.
Q. Prior to 1999 did IHC Health Plans contract directly with any pharmacies?
A. Between and probably prior to 1993, but up until 1996, IHC did contract directly with pharmacies. In 1996 IHC Health Plans made the decision to switch PBMs and go with Medco. As part of that PBM negotiation there was a change. IHC Health Plans made the decision to use the Medco pharmacy network.
Q. The reimbursement terms for the -- for IHC Deposition Exhibit 3 are set out on Page IHC AWP 149. Would you turn to that page.
A. Yes.
Q. At the bottom of the page there are some pricing terms. Do you see those?
A. Yes, I do.
Q. And those pricing terms are for brand name drugs payment at AWP minus 15 percent plus $2, or

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MAC plus $2; is that correct?
A. Yes.
Q. And for generic drugs it indicates that the price paid will be either the lower of AWP minus 15 percent plus $2.50 or MAC plus $2.50; is that correct?
A. Yes.
Q. Will you turn to Page IHC AWP 163 in Deposition Exhibit 4. And Deposition Exhibit 4 is the contract template that IHC Health Plans uses with independent pharmacies; is that correct?
A. Yes, it is.
Q. And pricing terms are, again, set out at the bottom of IHC AWP 163; is that correct?
A. Yes.
Q. And those pricing terms are identical to the pricing terms for chain pharmacies that are set out in IHC AWP 149, except that the discount off of AWP is 13.5 percent instead of 15 percent; is that correct?
A. Yes, it is.
Q. Would you please turn to Page IHC AWP 177

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in deposition -- IHC Deposition Exhibit 5. IHC Deposition Exhibit 5 is the contract template that IHC plan uses with rural pharmacies; is that correct?
A. Yes, it is.
Q. The pricing terms that are set out on Page IHC AWP 177 are identical to pricing terms that are set out in the contract templates for chain pharmacies and independent pharmacies, except that the discount off of AWP is ten percent instead of 13.5 percent or 15 percent; is that correct?
A. Yes, it is.
Q. Are there any other differences between the contract templates besides the difference -- the discounts off of AWP?
A. No, there is not.
Q. Okay. And AWP minus 15 percent represents a lower price paid by IHC Health Plans than AWP minus ten percent; is that correct?
A. Yes, it does.
Q. Why does IHC Health Plans pay a lower price to chain pharmacies than it does to independent pharmacies?

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A. We pay a lower price to chain pharmacies because we were able to negotiate a lower rate with chain pharmacies. Some of that revolves around the business model of a chain pharmacy versus an independent pharmacy. Independent pharmacies are less likely to be reliant on revenue from the front end of their store in things that are not prescription drug to keep their business profitable.

There is some belief, although I have no evidence of it, that because of the size of the chain pharmacies, the fact that they have warehouses, that their purchasing power is greater and they may be able to acquire the products for less money.

Q. Okay. And why does IHC Health Plans pay less to independent pharmacies than it pays to rural pharmacies?

A. Or why do we -- you got it reversed.

Q. Did I get it reversed?

A. We pay less to rural pharmacies than we do independent pharmacies, in that we define a rural pharmacy as a pharmacy that does not have any competition within a 25 to 30 mile radius.

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In that instance, and specifically within Utah, Idaho, Wyoming, there are very small towns that are reliant upon a single pharmacist to provide pharmaceuticals into that community. That pharmacist may not have the volume growth opportunity or the ability to have volume to make his revenue that even an independent pharmacy or a chain pharmacy has in a larger metropolitan area.

Also based on the fact that he has no competition. It puts us in a tighter negotiation situation in that we need that pharmacist in our network to provide coverage for our members.

Q. Let me see if I can characterize a little bit that testimony.

Is one of the factors that leads IHC Health Plans to pay more to rural pharmacies the competitive -- the competitive leverage that is exercised by rural pharmacies?

A. Yes.

Q. And does the variation in payments made by IHC Health Plans to chain pharmacies, independent pharmacies and rural pharmacies reflect, in part, IHC

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Health Plans' estimate of the acquisition costs of those pharmacies?

A. Yes, it does. Although we would also estimate that because a rural pharmacy is trying to survive on a much smaller volume in a much smaller community, that they may not be able to garner the purchasing power of a pharmacy in a larger metropolitan area.

Q. Each of the pricing terms that we went through previously for the contract templates has a discount off of AWP plus some fixed dollar amount; is that correct?

A. Yes, it does.

Q. What does the fixed dollar amount represent?

A. The fixed dollar amount represents a dispensing fee for dispensing that prescription. We are looking at, in the first part of the equation, the AWP minus or in the MAC establishing a discount for the cost of the product. The dispensing fee is in place in those situations where we need additional dollars to cover the labor or the bottled or the

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services provided by that pharmacy to our member in addition to the cost of the product.

We may have a product that we have discounted it AWP minus 15 percent. In a prescription the pharmacist may dispense one, two or three tablets, not allowing enough revenue to cover the cost of the services that were provided.

Q. Do you believe that the dispensing fees that you just discussed are sufficient to cover the pharmacy's costs of providing pharmaceutical pharmacy services?

A. No, I do not.

Q. Do you believe that pharmacies earn some margin on their sales of pharmaceutical products?

A. Yes, I do.

Q. Do you believe that pharmacies mark up their pharmaceutical products that they dispense and charge IHC Health Plans more than they paid to purchase those products?

A. Yes, I do.

Q. Why is the dispensing fee for generic products higher than the dispensing fee for branded

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products?
A. Generic products cost less, and so if you go into the example I gave earlier of two or three tablets, or even 30 tablets, there's less -- and with an aggressive MAC price there's less opportunity to make revenue on the generic product. And we believe that the pharmacist is entitled to make money on those prescriptions.
They also provide services for our members beyond simply giving them a prescription. They may be imparting knowledge, reviewing their pharmaceutical history, evaluating a patient's profile for drug interactions, drug age interactions, drug food interactions. And we need to provide compensation for those additional services provided.
We also pay more for generics on the dispensing fee in that generics cost us less money. It is in our best interest to incentivize pharmacists to dispense you generic drugs because it works towards our overall goal of keeping pharmaceutical costs down.
Q. Do you think that the margin that pharmacists earn on their sales of the pharmaceutical

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products differs based on the product?
A. Yes.
Q. IHC Health Plans pays pharmacies a standard for branded products at a standard discount off of AWP; is that correct?
A. Yes, we do.
Q. And in some cases that payment will represent a larger spread between the price that IHC Health Plans is paying and the price that the pharmacy purchased it than for other products; is that correct?
A. Yes.
Q. In setting the reimbursement rate for pharmacies is IHC health plans interested in the margins that the pharmacy may earn on a product by product basis?
A. No.
Q. In setting the reimbursement rates for pharmacies is IHC Health Plans interested instead in ensuring that pharmacies earn a reasonable margin on all of their -- the pharmaceutical products that they dispense?
A. Yes.

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Q. All right. I have some particular questions about the agreements.
If you would turn, please, to IHC AWP 140, which is in Exhibit 3. The last line of the first paragraph reads:
"This agreement does not apply to the IHCMed product unless Pharmacy has signed the separate IHCMed addendum."
Do you see that?
A. Yes, I see that.
Q. Why is the IHCMed product exempted from the contract?
A. The IHCMed product, as you'll recall from earlier discussions, is a limited network product in that we've attempted to reduce the size of that network to garner greater control over it and deeper discounts.
The IHCMed discount is AWP minus 15 percent plus $2 or 2.50 on generics. So technically all chain pharmacies, based on accepting an AWP minus 15 percent discount, would also accept automatically that AWP minus 15 percent discount for IHCMed.

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Independent pharmacies have to express greater willingness to participate in that network and accept that AWP minus 15 percent. That's a product that's only offered along the Wasatch Front, which would be 30 to 40 miles north of Salt Lake and 30 to 40 miles south of Salt Lake, and in the Park City area. So in that metropolitan area there are no rural pharmacies.
Q. About how many pharmacies have signed the separate IHCMed addendum?
A. I don't know. Most.
Q. Most pharmacies. Have most independent pharmacies as well as chain pharmacies?
A. Yes.
Q. In the definition of average wholesale price on Page IHC AWP 140, the contract template indicates that:
"The AWP shall be based on the quantity ordered by the Pharmacy (100, 500, 1,000) and not the price of a lower quantity."
Do you see that?

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A. Yes, I do.
Q. Does the AWP for a product differ based on quantity?
A. Yes, it does.
Q. How substantial, in your experience, are those differences?
A. Small, although I think there may be instances where if you went from a package size of 100 and looked at the per unit cost compared to the package size of a 5,000 count you may have as high as seven or eight percent difference.
Q. Is the -- is this definition referring to the quantity that is purchased by the pharmacy or the quantity that's dispensed by the pharmacy?
A. It's referring to the quantity purchased by the pharmacy. Did they purchase that product in a bottle of 100 or was it in a bottle of 500? Was it in a bottle of 1,000?
Q. Why is this qualification recommended to the definition of average wholesale prices?
A. First so that we obtain any price differential or discount in those pharmacies that are

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purchasing in bigger bottles. Secondly, so that we have an audit mechanism. We have contract language around what we expect the pharmacy to do.
Q. And have you audited any of the pharmacies with which you have contracts?
A. Yes, we have.
Q. What did you explore in those audits?
A. We explore in those audits was the product for which we were billed. Was it actually dispensed to the member? Is there evidence that the member picked up the prescription? If we were billed for a product coming out of a bottle with a quantity of 100, is that actually the bottle or the purchase history of the pharmacy?
We will look to see that a pharmacy may continually bill us for product coming out of the bottle size or bottle count of 100, yet on their shelves in the pharmacy they can still have bottles of 1,000 or 5,000.
Q. How do you determine the purchase history of a pharmacy?
A. We may ask for their purchase records.

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Q. To have pharmacies provide IHC Health Plans their purchase records?
A. In the past during audits we have not asked to see purchase records. Although based on the belief of an auditor, we may go back to a pharmacy and ask them to justify why we were billed with a bottle count of 100, yet upon audit they didn't have any bottle counts of 100 on the shelf.
Q. Does IHC Health Plans employ outside auditors for these audits?
A. We have used pharmacists that are employed by IHC Health Plans and we have contracted with outside auditors for these audits.
Q. So there are pharmacists who are employed by IHC Health Plans?
A. Yes, there are.
Q. In what capacity are they employed by IHC Health Plans?
A. I have currently a manager of pharmacy services that replaced me. I have two clinical pharmacists that work on more product by product reviews. They function much in the role I did as

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pharmacy utilization coordinator, looking at prior authorization, reviewing products for the pharmacy therapeutics committee, working with physicians on prescribing patterns or dissemination of clinical information.
Q. If you would turn now in the same exhibit to Page IHC AWP 144. In Section 3.8, which is titled "Formulary" the second to last sentence reads:
"Pharmacy agrees to comply with additional formulary and compliance programs implemented by IHC Health Plans."
Do you see that?
A. Uh-huh.
Q. What formulary compliance plans have been implemented by IHC Health Plans?
A. We have -- and I think this language is more out of asking the pharmacy to participate and accept our designation between formulary and non formulary. Specific programs are hard, in my mind, to come by. Although if you go back to 1997, '98 and '99, we had, and you'll recall in our structure, my

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explaining that we had a pharmacy call center. Formulary compliance programs would have been calling and saying such and such a patient has agreed, along with their physician, to switch from Product A to Product B. And this language is to make sure that that pharmacy is also willing to comply with that switch.

Q. Okay. Does IHC Health Plans reimburse for any non formulary pharmaceutical products?

A. Yes, we do.

Q. What's the basis of that reimbursement?

A. It's the same and -- is that a rate question or is that a why question?

Q. No. It is a rate question. At what rate does IHC Health Plans reimburse for non formulary to products dispensed?

A. We reimburse at the same rate for non formulary product that we reimburse for formulary products.

Q. Are the co-payments paid by members different for non formulary products than they are for formulary products?

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A. Yes, they are.

Q. What is the difference?

A. That would depend on the plan or the co-pay differentials purchased by that employer.

Q. In general are the co-payments for non formulary products higher than for formulary products?

A. Yes, they are.

Q. These are all template contracts, Exhibits 3, 4 and 5. And Exhibits 3, 4 and 5 all have pricing terms in them. Has IHC Health Plans entered into any contracts with pharmacies that have pricing terms different than those set out in the template contracts?

A. For products reimbursed under the pharmacy benefit, no.

Q. Are some pharmaceutical products reimbursed under a medical benefit?

A. Yes.

Q. Are those products -- are there any products dispensed by pharmacies that are reimbursed in the medical benefit?

A. Yes.

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Q. Has IHC Health Plans entered into any contracts with pharmacies for products reimbursed under medical benefit that have different pricing terms than those set out in Exhibits 3, 4 and 5?

A. Yes, we have.

Q. Which contracts?

A. There is an addendum to this contract that includes miscellaneous DME supplies and injectable drugs.

Q. I'm handing to you now a document that's been marked as IHC Deposition Exhibit 6.

(Exhibit Cannon 006 was marked for identification.)

Q. BY MR. EVERETT: Which is a document bearing the Bates Numbers IHC AWP 182 through IHC AWP 186. Do you recognize this document?

A. Yes, I do.

Q. What is it?

A. This is the amendment to the current retail pharmacy agreement that would include durable medical equipment, miscellaneous medical supply and injectable drugs.

Q. Is this the addendum to which you were

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just referring?

A. Yes, it is.

Q. Is IHC Deposition Exhibit 6 a document that was created and maintained by IHC Health Plans in the ordinary course of its business?

A. Yes, it is.

Q. Has IHC Health Plans entered into any contracts with the terms that are set out in IHC Deposition Exhibit 6?

A. Yes, we have.

Q. When was this amendment created?

A. My best guess -- I apologize that it's a guess -- is late 2002, early 2003. Possibly before that.

Q. And has IHC Health Plans offered to enter into contracts with pharmacies on the basis of the terms set out in IHC Deposition Exhibit 6 since late 2002 or early 2003 when the document was first created?

A. Yes, we have.

Q. Has -- has IHC Health Plans offered to enter into contracts having the terms set out in IHC

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Deposition Exhibit 6 with all of the retail pharmacies with which it has contracts?
A. No, we have not.
Q. To which retail pharmacies has IHC Health Plans offered to enter into an agreement along the lines of IHC Deposition Exhibit 6?
A. Those pharmacies that have expressed an interest in the ability to supply injectable drugs or miscellaneous medical supplies to our members. In general that has been limited to a few independent pharmacies. The retail pharmacies owned and operated by IHC, and to the best of my knowledge we don't currently have any chain pharmacies that are participating with this amendment.
Q. Prior to 2002 did IHC Health Plans reimburse for any durable medical equipment or miscellaneous medical supplies that were sold by pharmacies?
A. We would reimburse solely on the basis of a member paying cash or the full price to the pharmacy and then submitting the receipts to us.
Q. And for cash paying members were they

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paying what we previously referred to as usual and customary?
A. I would assume they were. I have no knowledge as to what they actually paid.
Q. And would IHC Health Plans reimburse its members for the full amount of payments they made to pharmacies for these types of products?
A. We would, less their co-insurance for member responsibility.
Q. Why did IHC Health Plans begin in late 2002 or early 2003 to offer this contract amendment?
A. We had very expensive injectable drugs that members could not afford to pay for up front that we needed to be able to provide reimbursement for. By nature of the fact that they were expensive injectable drugs, we wanted to be able to make sure we were paying our fee schedule and not just billed charges from a pharmacy.
Q. Are the injectable drugs that are covered by IHC Exhibit 6 injected by physicians in their offices?
A. No.

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Q. These products are -- how are these products administered?
A. These products would be self-administered injectables, and that we would assume the member could inject themselves with it or a family member could inject them.
Q. Let's talk a little bit about IHC Health Plans' previous relationships with PBMs.
You've testified previously that IHC Health Plans had a contract with Medco; is that correct?
A. Yes, that is correct.
Q. When did IHC Health Plans enter into that contract?
A. 1996. Effective date on the contract was 1996.
Q. What were the terms of the contract, if you recall?
A. As I recall the terms of the contract were for pharmacy claims processing services. And we paid Medco a per claim fee to process those claims, provide a contract pharmacy network and reimburse the

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pharmacies. We paid them as part of the term of that contract to provide help desk support for pharmacies and members as they may have questions or claims problems.
Q. Merck Medco -- or Medco created its own pharmacy network; is that correct?
A. They had a network in place at the time the contract was signed.
Q. Did IHC Health Plans contract directly with pharmacies during the period of time that it had a contract with Medco?
A. No, we did not.
Q. Did Medco contract with those pharmacies?
A. Yes, they did.
Q. Do you know the basis of payments made by Medco to the pharmacies of its network for pharmaceutical products dispensed to members of IHC Health Plan?
A. No, I do not.
Q. Did you ask Medco what it was paying pharmacies for products dispensed to members of IHC Health Plan?

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A. Yes, I did.
Q. And what did they tell you?
A. That pharmacies were being paid what I was being charged, which at the time was AWP minus the 13 percent plus $2 or 2.50. And the AWP minus was the lower of AWP minus or MAC.
Q. Did you believe Medco?
A. No.
Q. Why not?
A. Based on conversations with pharmacists they would tell me that they were being reimbursed less. It was my recollection, although not perfect recollection at the time, that when I worked in the community we were being reimbursed less. And at the same time I knew there were also pharmacies that were being reimbursed more.
Q. Did you believe that the per claim fee paid by IHC Health Plans was sufficient to cover the costs associated with all of the services provided by Medco to IHC Health Plans?
A. Yes, I did.
Q. Is there a competitive market for

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providing pharmacy benefit management services?
A. Yes.
Q. Prior to entering into a contract with Medco in 1996, did IHC Health Plans have contractual relationship with any other PBM?
A. Yes, they did.
Q. Which PBM?
A. Argus.
Q. For what period of time did IHC Health Plans have a contract with Argus?
A. 1993 through the end of 1995.
Q. Why did IHC Health Plans decide to change from Argus at the end of 1995?
A. I don't know. That's prior to my coming to IHC.
Q. At the end of 1995 did IHC Health Plans solicit bids from more than one PBM?
A. I would assume they did. I don't know.
Q. Do you know if IHC Health Plans made a formal request for proposal from PBMs at the end of 1995?
A. No, I do not.

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Q. Do you know the terms of the contract that IHC Health Plans had with Argus?
A. The terms of that contract included a per claim fee to cover the processing of claims. All pharmacy help desk services, member help desk services, were internal to IHC. IHC contracted the pharmacy network and paid the pharmacy network. Under that arrangement Argus was, from the best I can tell, simply processing the claims.
Q. Do you know the terms of IHC's contracts with pharmacies in the period prior to 1996?
A. I know generally where they were, although it's been quite some time since I've actually looked at those contracts. They were in the range of AWP minus ten percent to 20 percent.
Q. And the contract that IHC Health Plans entered with Medco in 1996 -- strike that.
Under the contract that IHC Health Plans had with Medco starting in 1996, IHC Health Plans paid Medco AWP minus 13 percent for drugs dispensed through pharmacies; is that correct?
A. That is correct.

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Q. And so IHC Health Plans was paying less for products dispensed through pharmacies under its contract with Medco than it was prior to its contract with Medco; is that correct?
A. Yes, that's correct.
Q. Did the contract with Medco have any provisions dealing with rebates from manufacturers?
A. Under the contract with Medco, as I recall there were to be no rebates collected from manufacturers by Medco. That all manufactured contracting and rebates were to be handled by IHC internally.
Q. And as you testified previously IHC Health Plans, during the period from 1996 to 1999 when it had a contract with Medco, independently contracted with pharmaceutical manufacturers for rebates; is that correct?
A. Yes, that is correct.
Q. And those rebates had the affect of decreasing the cost of pharmaceutical products paid by IHC Health Plans; is that correct?
A. Yes.

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Q. When did the contract with Medco expire?
A. It expired December 31st of 1988 and was extended through September 30th of 1999.
Q. Just to clarify, it expired at the end of 1998?
A. Yes. It was '96, '97, and '98. So three year contract. In October, November of 1998 we made a decision to more closely evaluate our current arrangement with PBM. In the fall of 1998 we did issue an RFP looking at PBM vendors and data service center providers that might meet our needs. And then in January of '99 the contract was extended for nine months to accommodate our switching.
Q. How many responses did you receive to the RFP that was sent out at the end of 1998?
A. Five or six.
Q. Is that five to six responses from PBMs?
A. That would be from four or five true PBMs, and then one response from Prospective Health, which was more a software vendor service center provider.
Q. Did the responses by the four to five

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PBMs to IHC Health Plans RFP vary?
A. Yes.
Q. In what way did they vary?
A. They varied in the level of services that could be provided. They varied in the flexibility of the platform they offered for claims adjudication. They varied in terms of pharmacy network size, levels of discounts that could be garnered. They varied in the level of performance guarantees they were willing to offer. They varied in the level of services they were willing to provide for IHC or the control they were willing to allow IHC to have over the adjudication of claims.
Q. Did any of the RFP's -- strike that. I'm sorry.
Did any of the responses to the RFP indicate that a PBM intended to earn a margin between the price at which it paid the pharmacies for pharmaceutical products and the price that it charged IHC Health Care?
A. Yes.
Q. Which PBM?

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A. MedImpact.
Q. Do you recall what terms it was offering in that respect?
A. I think we had asked for a -- I can't exactly recall what terms we had asked for in the RFP, or if we had even asked for specific terms. I do recall that within the RFP we had a question asking how the PBM would document and guarantee to us that the terms negotiated with the pharmacy were actually the terms that IHC Health Plans would pay for claims.
And the template contract -- and I can't remember the exact explanation to the question from MedImpact -- but I do remember discussions that we had on the phone with MedImpact at the time over language in the template contract or boiler plate contract that was in the RFP that indicated that if MedImpact could achieve deeper discounts from pharmacies, they would guarantee an overall network rate to us, but deeper discounts or a spread they were allowed to keep.
Q. And is that a pricing term that was attractive to IHC?
A. No.

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Q. Were MedImpact's other fees lower as a result of the potential to earn a spread?
A. No.
Q. The other responses to the RFP indicated that the PBM responding to the RFP did not intend to earn a spread on pharmaceutical products that were reimbursed to the pharmacies?
A. I don't recall. I think, quite honestly, in looking at some of the pricing terms over the size of some of the PBMs or going off of past history with previous PBMs, some of those questions did not come up because the true willingness of IHC to ultimately go with that provider probably didn't exist.
Q. In deciding which PBM to contract with was it important for IHC Health Plans to evaluate all of the terms in the contract?
A. Yes.
Q. Including level of services?
A. Yes.
Q. Including the flexibility of their platforms?
A. Yes.

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Q. Including the size of their pharmacy networks?
A. Yes.
Q. Including any performance guarantees that were offered as part of the contract?
A. Yes.
Q. Ultimately IHC Health Plans decided not to contract with the PBM in 1999; is that correct?
A. Yes, that is.
Q. And how did IHC Health Plans decide to essentially take the pharmacy benefit management services in house?
A. In looking at the arrangement that we had at the time with Merck Medco, in looking at an evaluation of our claims that had been processed by Medco, we came to the determination that there were various areas by which we could save money if we were to switch away from Medco and correct some of those ongoing issues.
Q. In which areas did IHC Health Plans believe it could save money compared to its contract with Medco?

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A. We had, at the time, documented lost money based on system setup issues with Medco. The designated products to process one way when they should have processed another. So we had some money that we believed we could save there.
At the time I was doing an evaluation of generic products and what they were being purchased for and what Medco was reimbursing them at or were they at their MAC price set. We believed there was opportunity in a deeper discount. We believed that there was money to be saved in the administration charge that was being charged to IHC by Medco. So in the per claim fee we paid we believed we could reduce the amount we paid.
Medco had a standard protocol in place that only allowed pharmacies a 15 day window in which they could reverse claims. So if a physician called a pharmacy and said, you know, I want to renew this prescription for Member XYZ, and that member never came to pick it up, the pharmacy only had 15 days to reverse it.
Having worked in retail it's not standard

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practice to reverse your claims every 15 days. You'll usually give someone, depending on the type of drug, up to 30 days to come in and pick that up.
We felt that there was -- there were many products that were going that ultimately had never been delivered to members, but because of processing parameters within Medco those charges were never being reversed back to us. We believed there were savings in increasing the discount to the -- that we were getting from the pharmacies. We believed there were savings in being able to have your flexibility in the way the system was set up.
Q. Okay. Does IHC's size in the Utah market influence its ability to negotiate lower payment rates with pharmacies?
A. In negotiating with pharmacies our size is helpful in that we represent a large number of the patients. At the same time as we negotiated contracts our size was also, to a certain degree, a hindrance in that because we represented so many of the patients, that one of the arguments we heard from the pharmacies in negotiation was, you know, you represent such a

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large portion of my business that, you know, if I take this big reduction in revenue it will ultimately affect my bottom line.
Q. On net do you think that smaller managed care organizations or insurance companies could negotiate better rates with pharmacies than IHC Health Plans?
A. No.
Q. Do you believe that smaller managed care organizations or insurance companies in Utah could negotiate better rates with pharmacies than were being offered by PBMs?
A. No.
Q. During the period of time that IHC Health Plans had a contract with Medco, did it ever audit Medco?
A. Yes, we did.
Q. What types of audits were performed?
A. We would audit in the system setup. That was the main type of audit that was performed, where we would look at when we communicated to them the status or processing parameters for a certain drug,

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and then we would audit to make sure that actually took place and was happening.
Q. Does IHC also own pharmacies?
A. IHC Health Systems, Inc. owns pharmacies.
Q. How many?
A. Presently 19.
Q. For how long has it owned pharmacies?
A. There's been some number of pharmacies owned by IHC as long as I've been at IHC.
Q. Do you gather information from the IHC Health Services pharmacies in making your educated guess about acquisition costs of the pharmacies with which IHC Health Plans contracts?
A. Yes.
Q. Would it be possible to estimate acquisition costs for MAC pricing purposes even in the absence of ownership of pharmacies?
A. Yes, it would.
(Exhibit Cannon 007 was marked for identification.)
Q. BY MR. EVERETT: I am handing to you a document that's been marked as IHC Deposition Exhibit 7. And for the record that is a document

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bearing the Bates Numbers IHC AWP 28 through IHC AWP 43. Take a moment and look through that document.
Are you familiar with that document?
A. Yes, I am.
Q. And what is the document?
A. This is a contract between IHC Health Plans and Accredo.
Q. Is this a document that was created and maintained by IHC Health Plans in the ordinary course of its business?
A. Yes, it is.
Q. What is Accredo Health?
A. Accredo Health is a supplier of specialty injectable products.
Q. Is it also known as a specialty pharmacy?
A. Yes, it is.
Q. The contract is dated August 1st, 2003; is that correct?
A. Yes, it is.
Q. What -- how did IHC reimburse for the special fee pharmacy products that are subject to this agreement prior to August 1st, 2003?

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A. Prior to August 1st, 2003, they were still -- they were reimbursed under an injectable fee schedule that for pharmacies of this nature would receive reimbursement at AWP plus five percent.
Q. And what is the reason that IHC Health Plans entered into the contract with Accredo?
A. It provided us an opportunity to decrease the amount we pay for these products.
Q. Are these products dispensed through pharmacies or by providers?
A. These products are dispensed through pharmacies, for the most part.
Q. You mentioned that prior to August 1st, 2003, IHC Health Plans reimbursed pharmacies for these specialty pharmaceutical products at AWP plus five percent; is that correct?
A. Yes.
Q. During the same period of time IHC Health Plans had contracts with pharmacies to reimburse them for other pharmaceutical products at a discount off of AWP; is that correct?
A. Yes.

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Q. Why was IHC Health Plans reimbursing pharmacies at a higher rate for these specialty pharmaceutical products than for other pharmaceutical products?
A. These products involved more education with the member on how to use it. They require that the pharmacy is willing to bill us on a paper claim or a HCFA 1500 form. Most of these products have specialized storage or dispensing requirements that make them much more complicated to provide than your traditional pharmaceutical products. And they're also much more expensive. And under an AWP minus scenario, most pharmacies would not be able to make money dispensing these products.
Q. IHC Health Plans' willingness to pay more for these products was driven by the desire to make sure that the pharmacies earned sufficient margin to cover the costs associated with providing services associated with these products; is that correct?
A. No. I don't know that we paid more simply to allow the pharmacies to make a margin or not make a margin, but make a bigger margin. I think

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IHC's willingness to pay more for these products was out of market dynamics that we had to pay more for these products so that we could meet the clinical needs and health needs of the patients for whom we insure.

Q. Pharmacies were unwilling to accept less for these products than IHC Health Plans paid; is that correct?

A. Yes.

Q. Under your contract with Accredo how are pharmaceutical products that are the subject of the agreement dispensed?

A. They're dispensed out of a pharmacy, and I think there may be -- I don't recall. There may be some locally here. No, they're not. They're dispensed out of one of the pharmacies that Accredo owns and then shipped to a member after an order from a physician.

Q. Okay. If you turn to Pages IHC AWP 35 through 36. There is a list of drugs and a price list; is that correct?

A. Yes.

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Q. And the far right-hand column of the price list is titled "AWP Discount"; is that correct?

A. Yes.

Q. Do those discounts vary?

A. By product?

Q. Yes.

A. Yes.

Q. What explains the variation in the discount off of AWP by product?

A. That would indicate the ability of them to get deeper discounts for manufacturers on their acquisition cost of those products.

Q. In your opinion is Accredo earning a margin on their drug sales to IHC Health Plans pursuant to this contract?

A. Yes, they are.

Q. So its net purchase price from manufacturers is, in your opinion, lower than the price paid by IHC Health Plans?

A. Yes.

Q. Is there any means of paying Accredo pursuant to the contract other than the difference in

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the price paid by IHC Health Plans and the price paid by Accredo to manufacturers or wholesalers?

A. Ask me that again.

Q. Yeah. The contract between Accredo and IHC Health Plans only includes price terms for the purchase of pharmaceutical products; is that correct?

A. Yes.

Q. Are there any other payments made pursuant to the contract?

A. No.

Q. Okay. Let's take one more break, because this is a pretty good breaking point for me. And then I want to turn to some contracts that you produced regarding providers.

(There was a break taken.)

MR. EVERETT: Let's go back on the record.

Q. I'd like to talk about the physician administered drugs. Are you familiar generally with the reimbursement methodologies used by Intermountain Health Care for physician administered drugs?

A. Yes, I am.

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Q. To your knowledge are physician administered drugs reimbursed by IHC Health Plans on the basis of a discount off of AWP?

A. Yes, they are.

Q. Has that been true as long as you have been working for IHC Health Plans?

A. When I initially started with IHC in 1997 we paid physicians a percent of billed charges for business administered drugs.

Q. When did -- sorry.

A. Sometimes -- and I'm -- I can't remember exactly when -- we moved towards a AWP based reimbursement for physicians.

Q. Do you know why IHC Health Plans moved to an AWP discount for reimbursing physicians for physician administered drugs?

A. It was a better discount for us, more reflective of the cost of the product dispensed or used in the office.

Q. Do you know whether in general the billed charges of physicians for physician administered drugs is higher than or lower than AWP?

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A. It was higher than AWP.
(Exhibit Cannon 008 was marked for identification.)
Q. BY MR. EVERETT: I'm going to hand to you now a document that has been marked IHC Deposition Exhibit 8. For the record it's document bearing the Bates Numbers IHC AWP 136 through IHC AWP 138. Have you had a chance to look at this document?
A. Yes, I have.
Q. And are you familiar with the document?
A. Yes, I am.
Q. What is it?
A. This is the fee schedule for injectable drugs at IHC Home Care Services. IHC Home Care is the home health care provider for IHC Health Plans, and also in the context of specialty pharmacy acts as our primary specialty pharmacy vendor.
Q. Is IHC Home Care Services affiliated with Intermountain Health Care?
A. Yes, it is.
Q. In what way?
A. IHC Home Care is a facility within the IHC Health Systems, Inc. corporation.

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Q. So it is, in essence, a sister company to IHC Health Plans; is that correct?
A. Yes.
Q. When was this contract entered?
A. We entered into this contract at the same time that we entered into the agreement with Accredo. Negotiations took place simultaneously.
Q. Is there a reason that you negotiated this contract at the same time as the contract with Accredo?
A. Even though we may be brothers and sisters within the IHC family, we're still driven by competitive market forces. And Accredo was pushing very hard to obtain and garner some of the IHC Health Plans' business. It provided an opportunity by which we could sit down and establish competitive market prices for these injectable drugs, even though it was with a sister company.
Q. Prior to entering into this agreement what arrangements, if any, did IHC Health Plans have with IHC Home Care Services?
A. We paid IHC Home Care Services billed

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charges.
Q. And what, in general, was the relationship between IHC Home Care Services billed charges and AWPs for the products that are the subject of this agreement?
A. I think it varied. There were some products that were more than likely already being reimbursed at, even though they were -- we were paying billed charges they were still being reimbursed or paid at rates similar to these other products. Their billed charges would have been higher and not as competitive with those of other specialty providers.
Q. Do you have a general understanding of the prices that IHC Home Care Services pays for these drugs?
A. No, I really do not.
Q. Through the coordination procedures that we discussed previously, do you have an understanding generally of the prices paid by IHC services generally for pharmaceutical products?
A. Under that understanding I would assume they're purchasing the products for less. Much closer

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to WAC or even based off of arrangements with wholesalers and other vendors for less than WAC.
Q. Have you ever asked representatives of IHC Home Care Services what they pay for pharmaceutical products?
A. On some products, yes.
Q. In what context did you have those discussions?
A. I think initially we discussed -- we've had ongoing discussions with IHC Home Care over the years about the products they supply to our members and the most cost effective way of supplying those, or can they provide products competitively with competitors in the marketplace.
Specifically I think we had discussions about what they could purchase growth hormone for versus what we were paying for it. And even to the point as we looked at growth hormone products, there are five in the category, and could we standardize to two. That would provide cost savings for IHC Health Plans.
Q. How do your negotiations with other IHC

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entities differ from negotiations with entities with which IHC doesn't -- in which IHC doesn't have an ownership interest?

A. They're more difficult. I think as in negotiations that occur in a family between brothers and sisters there's some sense that they deserve more and the negotiations become harder and more drawn out. And because it is a sister company we have a desire to -- to work with them; maintain a cordial relationship. Many tactics that one would normally undertake in a business negotiation are more taxing under that situation than in a normal negotiation.

Q. At the end of the day do you think that IHC Health Services got a good deal with this contract?

A. IHC Health Services was able to maintain volume going through IHC Health Plans with this contract. I don't know that I'm in a position to say they got a good deal one way or the other.

Q. And do you think that IHC Health Plans got a good deal from this contract?

A. Yes, I do.

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Q. The contract has pricing that pays a discount off of AWP varying from AWP minus ten percent to AWP minus 47 percent; is that correct?

A. Yes, that is correct.

Q. What explains the variation in AWP discounts?

A. The variation in discounts is driven by their ability to purchase that product for less, much less than AWP and still, I would assume, maintain a profit margin.

Q. Most of the prices in the contract are AWP minus 14 percent?

A. Yes.

Q. What did you use to determine that discount for the majority of the products?

A. I think that discount was determined based on as we looked at the contract we actually sent a list of these products in the form of an RFP to IHC Home Care. Accredo also received the RFP and several other specialty providers, and we asked them to provide us with the discounts that they could provide on these products. AWP minus 14 percent on most of

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these products is what IHC Home Care came back to us with.

Q. So the payment rates that are reflected in this contract are the result of competition?

A. Yes, they are.

Q. Okay. Some particular questions about the contract. On Page IHC AWP 136.

A. Yes.

Q. In the middle of the paragraph at the top of the page it indicates that:

"All pharmaceuticals and supplies (such as needles, syringes and alcohol swabs) associated with therapy are included in the AWP reimbursement pricing."

Do you see that?

A. Yes, I do.

Q. The prices that are identified in the contract are intended to pay not only for the pharmaceutical products, but also these other supplies; is that correct?

A. Yes, it is.

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Q. How would you determine how much of each payment was for the drug itself as opposed to the associated supplies?

A. I can't.

Q. So you'd have to look at it just as a bundle?

A. Yes.

Q. Does IHC Home Care Services also provide services associated with these pharmaceutical products?

A. Yes, they do.

Q. And are those services also included in the price lists that's identified in this contract?

A. No, they are not.

Q. And how are those services paid for?

A. Nursing services, education services, are paid under a separate arrangement.

Q. Okay. The next sentence in that paragraph reads:

"All other injectable therapies not listed specifically in the table below will be reimbursed at 75% of

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billed charges until a specific discount off AWP is agreed upon and amended into this Agreement."
Is that correct?
A. Yes.
Q. Are there products for which IHC Health Plans pays IHC Home Care Services as a percentage of billed charges?
A. Yes, there are.
Q. In general how many products are paid on that basis?
A. A lot. You know, I have no way of saying an exact number. There are several that are paid under that mechanism.
Q. If one were to look in the claims data of IHC Health Plans would you be able to differentiate between products paid on the basis of AWP and products that, subject to this agreement, were paid as a percentage of billed charges?
A. If you didn't have this list of codes you would not be able to determine or ascertain as to why a claim or what rate it was paid at.

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Q. So the claims database just indicates a price paid for a product; is that correct?
A. Yes.
Q. And doesn't indicate the basis for that price?
A. Right.
Q. Okay. The prices that are identified in IHC Deposition Exhibit 8 are based on HCPC codes; is that correct?
A. Yes, it is.
Q. To your knowledge do HCPC codes for pharmaceutical products often incorporate within them products that would be separately identified by different NDC numbers?
A. Yes, they do.
Q. And are AWPs published based on NDC numbers?
A. Yes.
Q. How do you determine what AWP to use when reimbursing for a pharmaceutical product based on a HCPC code?
A. We currently purchase from a company

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called R.J. Health a methodology or fee schedule that takes all NDC numbers and rolls them to their particular J-codes and says this NDC number applies to this J-code.
Q. Okay. If there are differences in AWP prices based on an NDC code and a J-code includes several NDC numbers, how do you decide which AWP price to use in making payment pursuant to this agreement?
A. R.J. Health has a methodology by which they roll those NDC codes together and take an average of those. Their method varies between brand and generic, and even in some instances throws out the high and the low, as I understand it, although I don't intimately know the specifics of that methodology.
Q. Okay. Do you know how it varies between brand and generic?
A. And if in a -- in a category there's branded products and a generic products, the price is set based on the generic products, not the branded products. If there's a generic available we're going to reimburse for the generic and the similar provider should use the generic product.

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Q. Okay. If you were to look in the claims database kept by IHC Health Plans would you be able to determine what AWP was used as the basis for reimbursement pursuant to this contract for any particular item?
A. You would be able to look in the claims database and based on the allowed for that particular product and extrapolate backwards based on does that fall under an AWP minus 14 percent reimbursement you could get at the AWP that was used.
Q. But it would involve some further investigation; is that correct?
A. It would be very difficult.
(Exhibit Cannon 009 was marked for identification.)
Q. BY MR. EVERETT: I'm handing to you now a document that's been marked as IHC Deposition Exhibit 9. It's a document bearing the Bates Numbers IHC AWP 56 through IHC AWP 75. Take a couple minutes and look at the document.
A. Okay.
Q. Are you familiar with this document?
A. I have seen it before.

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Q. Okay. Can you tell me what it is.
A. It is a participating provider agreement between IHC Health Plans and Total Renal Care for outpatient dialysis services.
Q. Was this document created and maintained by IHC Health Plans in the ordinary course of its business?
A. Yes.
Q. What's the date of this?
A. The term is from sometime in 1999 to -- I have to look at the date exactly. It's from September 1st, '99, through December 31st, 2004.
Q. Do you know if IHC Health Plans had a contract or contracts for the provision of outpatient dialysis prior to 1999?
A. I do not know.
Q. If you would turn, please, to Page IHC AWP 66. Paragraph 1 appears to indicate that IHC Health Plans will pay a fixed dollar amount of $239 for hemodialysis treatment, including all routine drugs and routine laboratory tests; is that correct?
A. That is correct.

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Q. And that flat fee would include payment for the routine drugs that are identified in Exhibit B-1 or Schedule B-1 to the contract; is that what the paragraph indicates?
A. Yes, it does.
Q. Is there any way, to your knowledge, to determine what portion of the $239 flat payment is made for the routine drugs that are dispensed as part of the hemodialysis treatment and what portion relates to other products and services?
A. To my knowledge there is no way.
Q. How did IHC Health Plans determine the amount of the payment it was going to make pursuant to this contract?
A. That I don't know as I was not party to the negotiations on this contract.
Q. In general what factors does IHC Health Plans take into account in setting prices that it pays to providers?
A. The general practice would be in this instance to look at other competitive providers, possibly. But I'm not certain. An RFP would be

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issued to get a competitive feel for what the prices are in the market. They'd look at the costs we were currently paying versus the costs that were outlined in this contract and do an evaluation.
Q. Are the rates paid to providers driven by competition?
A. Yes.
Q. And IHC Health Plans tries to negotiate for the lowest price that it can pay to providers; is that correct?
A. Yes, that is correct.
Q. Again on Page IHC AWP 66, if you look at Paragraph 3 it indicates that non routine drugs will be paid at the lesser of plans then applicable fee schedule or the amount charged and billed. Do you see that?
A. Yes, I do.
Q. What is the fee schedule to which that provision of the contract is referring?
A. That would apply to the general fee schedule that we have in place for outpatient physician clinics in other infusion centers or

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facilities of this nature.
Q. Does IHC Health Plans have different fee schedules for different types of providers?
A. Yes, we do.
Q. Does IHC Health Plans have different fee schedules for its different products?
A. Yes, we do.
Q. Do those -- do all of those fee schedules reimburse providers for pharmaceutical products based on AWP?
A. Generally speaking they all reimburse providers based on AWP. Currently in the injectable fee schedules for outpatient use all of the products, except 51 codes, are reimbursed at AWP plus five percent. And there are, under IHC Direct, there is one fee schedule that the fee schedule reimburses at AWP plus ten percent.
The 51 excluded codes are oncology codes or oncological products that are reimbursed at a percent off billed charges.
Q. Are some payments pursuant to this contract made on the basis of billed charges instead

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of the fee schedules that are published by IHC Health Plans?
A. On this contract with Total Renal Care?
Q. That's right.
A. I'd have to look and see if they're billing us for any of the oncology products that are in that 51 codes. I don't know.
Q. Okay. Well the contract itself indicates that the payment will be the lesser of the applicable fee schedule or billed charges.
A. And the applicable fee schedule would be for each one of the codes there is set an AWP plus five percent fee or a corresponding percent of billed charges.
Q. I see.
(Exhibit Cannon 010 was marked for identification.)
Q. BY MR. EVERETT: I'm going to hand to you a document that has been marked as IHC Deposition Exhibit 10. It's a document bearing the Bates Numbers IHC AWP 103 through IHC AWP 134. And just so you know, it's a two-sided copy.
A. What you gave me is an additional copy of

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the --
MR. LAWLOR: I got the same thing.
Q. BY MR. EVERETT: Take a moment and look through that contract.
A. Okay.
Q. Are you familiar with this document?
A. Yes.
Q. And what is it?
A. This is the standard participating provider agreement between IHC Health Plans and physicians.
Q. To your knowledge was this document created and maintained by IHC Health Plans in the ordinary course of its business?
A. Yes.
Q. Did IHC Health Plans enter into any actual contracts with providers based on the terms that are set out in IHC Deposition Exhibit 10?
A. Yes.
Q. Did IHC Health Plans enter into contracts with providers that used different terms than those set out in IHC Deposition Exhibit 10?

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A. That I don't know.
Q. The footer at the bottom of each page has what looks to me to be a date. Do you see that?
A. Yes.
Q. And what do you understand 8/97 to mean?
A. I would assume that's when this contract was drafted and initiated.
Q. And do you understand -- strike that.
Has this form contract been used by IHC Health Plans, to your knowledge, since August of 1997?
A. Yes.
Q. And if the form contract had changed since August of 1997 there would be a different date at the bottom of the contract; is that correct?
A. Yes.
Q. If you will turn, please, to IHC AWP 113. And Section 3.01 the contract indicates:
"Fee schedules and/or formulas for determining fee amounts may provide for different payments for the same procedures depending on the number of Members seen by Provider in a

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specified period of time or other specified criteria."
Do you see that?
A. Yes.
Q. How does the number of members seen by a provider affect fee amounts paid by IHC Health Plans?
A. We have providers that based on the volume they see with us receive a different fee schedule. Now I don't understand or know the entire methodology by which they calculate which fee schedule to use. I don't know if that methodology is currently in place or being used.
Q. Based on the methodology that you've just described generally, would it be possible that a physician would be reimbursed different amounts and different times based on the number of members that he has seen at a particular time?
A. For a physician administered drug, no.
Q. And why are physician administered drugs treated differently?
A. I don't know that they are. But my knowledge is on the pharmaceutical products, not on

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the other services or procedures provided in a physician's office.
Q. Does IHC Health Plans have any capitation contracts with the providers?
A. Not currently that I am aware of.
Q. Did it have capitation contracts with providers in the past?
A. I'm unaware.
Q. If you will turn, please, to IHC AWP 121. At the bottom of the page and carrying over into Page 122 indicates that:
"Provider will be paid [at] the lesser of [the] Provider's current prevailing fee or the amounts on the Health Choice Maximum Allowable Fee Schedule."
Do you see that?
A. Uh-huh.
Q. Are prescription drugs included on the maximum allowable fee schedules?
A. Yes, they are.
Q. And are there different maximum allowable

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fee schedules for prescription drugs for different products sold by IHC?
A. Yes, there are.
Q. Did IHC Health Plans understand that providers were earning some margin on their sales of physician administered drugs?
A. Yes.
Q. Are there any particular groups of physicians that are must haves for the IHC Health Plans now?
A. IHC Health Plans must maintain a provider network that meets the medical needs of our patients. So we must have adequate numbers of primary care physicians that would include internal medicine, family practice, pediatricians. We must have adequate numbers of specialty providers, whether they are orthopedic surgeons, hematologists, oncologists, rheumatologists, neurologists.
Is anyone of those providers a must have over the other? I don't think, although from time to time there may be a specialty with whom we are more challenged to have access than another.

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Q. Are there separate negotiations with providers about fee schedules?
A. Yes.
Q. Do different providers -- are different providers paid based on different fee schedules by IHC Health funds?
A. For injectable drugs all providers are paid off the same fee schedule -- or physician -- it would be better if I said physician administered drugs as opposed to injectables.
Q. So there's a single fee schedule for all physician administered drugs?
A. Yes.
Q. Have any providers threatened to leave IHC Health Plans network due to the amount that's included on the fee schedule for physician administered drugs?
A. Yes.
Q. And how did IHC Health Plans respond to that threat?
A. The threats that I'm thinking of were in response to our negotiating over lowering the price we

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currently paid or changing the reimbursement methodology for injectable drugs, and it centered around rheumatologists.
Q. And did IHC Health Plans maintain its contractual relationship with those rheumatologists?
A. Yes, we did.
Q. Did IHC Health Plans change its methodology or lower its payment for physician administered drugs to those rheumatologists?
A. No, we did not.
Q. Did IHC Health Plan try to figure out providers cost in determining the amounts that they would agree to reimburse based on a fee schedule for physician administered drugs?
A. Can you repeat that.
Q. Sure. Did you try to figure out what physicians were paying for drugs that were reimbursed by IHC Health Plans?
A. I don't think we tried to figure out what they were paying. I think we had a ballpark idea of what they were paying. Did we do an analysis or go to a lot of work to figure out? No.

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Q. And what was your ballpark idea what they're paying?
A. I think we estimated that they were more than likely paying WAC or a small discount off of WAC for those products.
Q. I know you've testified about this previously, but what do you believe is the relationship between WAC and AWP?
A. WAC being a closer representation of actual price, purchase price of the product. AWP being more a suggested retail price or resale price.
Q. And in terms of -- is AWP a standard markup over WAC?
A. Yes, or could be.
Q. Of approximately how much?
A. I think our understanding is in the neighborhood of 21, 22 percent for most manufacturers, with some manufacturers as low as 17.
Q. And according to its fee schedules, IHC Health Plans reimburses providers for physician administered drugs at AWP plus five percent, generally; is that correct?

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A. Yes.
Q. And your ballpark idea of what providers were paying was approximately WAC or slightly lower; is that correct?
A. Yes.
Q. So you believed that providers were earning a margin on their physician administered drug sales of approximately 25 percent?
A. Yes, that's fair.
Q. Why was IHC Health Plans willing to afford providers a margin that large?
A. I would guess you need to talk to various people, because some people may say that's a very large margin. If you're talking to somebody selling jewelry that marks their product up 200 percent, they would say that's not a very big margin.
So I think we have come to the conclusion that the margin we've allowed is a fair margin for the services provided by the physician.
Q. And in general does IHC Health Plans reimburse providers at the lowest rate that the competitive dynamics of the market will allow?

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A. Yes.
Q. Is it more expensive to IHC Health Plans to reimburse for drugs administered through hospitals or in an outpatient setting?
A. That I don't know. We've never undertaken that analysis.
Q. In general does IHC Health Plans have a preference between outpatient administration of drugs and inpatient administration of drugs?
A. No, we do not.
Q. The dispensing of pharmaceutical products by providers -- strike that.
Are there services associated with dispensing pharmaceutical products by providers?
A. Yes, there are.
Q. And are those services separately reimbursed by IHC Health Plans?
A. Yes, they are.
Q. Do you have any understanding of whether the amount paid for administration services associated with physician administered drugs are sufficient to cover provider's costs associated with those services?

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A. In the providers we've worked with and talked to, depending on the product being supplied, the circumstances of the patient, they may be sufficient to cover the costs associated with providing those services.
In other instances -- and oncology is one that comes to mind -- where the fees paid for infusion services or ancillary services in conjunction with the drug, it is the belief of the providers that it is not enough to cover the additional services provided.
Q. And does -- is IHC Health Plans willing to pay more for physician administered drugs in part to subsidize the provision of services associated with administering those drugs?
A. We know that's a reality of what we have to deal with.
Q. Okay. Are the fee schedules for procedures and services, other than the prescription drugs, based on Medicare fee schedules, do you know?
A. The fee schedule that exists today for injectable drugs provided in a physician's office that was originally negotiated or discussed was that we

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would pay the Medicare rate plus ten percent. As I understand the current Medicare rate on injectable drugs it's AWP minus five percent. So at our current rate of AWP plus five percent we are paying Medicare plus ten percent.

Q. Are you familiar with media reports that the federal government believes it is over paying for physician administered drugs reimbursed by Medicaid?

A. Yes, I am.

Q. And yet IHC Health Plans still reimburse at the Medicare rate plus ten percent; is that correct?

A. Yes, we do.

Q. Why?

A. I think you've asked the question or raised the issue several times. Competition. What do we need to do, what do we need to pay to provide services for our members? And during the course of ongoing negotiations with physicians and as market dynamics change, I would hope we can reduce what we pay. But currently the current market dynamics we exist within require us to pay those rates.

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Q. Are you familiar with the documents produced and the electronic data produced by IHC in response to the subpoena in this case?

A. Yes.

Q. Included in the production were two CD ROMs. One that had a 2004 injectables fee schedule and one that had a maximum allowable fee schedule for a number of years.

A. Yes.

Q. Are you familiar with all of the files on those two CD ROMs?

A. Not intimately familiar with the files, but generally, and the information contained therein, yes.

Q. Okay. For all of that electronic data -- strike that.

Was all of the information included on those two CD ROMs created and maintained by IHC Health Care in the ordinary course of its business?

A. Yes.

Q. Were the fee schedules included in electronic form on those two CD ROMs used by IHC Health Care in reimbursing providers for services and products that they provided to IHC Health Care's members?

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A. Yes.

Q. Are physician administered drugs included -- strike that.

Is the payment rate from IHC Health Plans identified anywhere in the maximum allowable fee schedules that are generally published by IHC Health Plans?

A. Yes.

Q. Is there a separate fee schedule for physician administered drugs?

A. No.

(Exhibit Cannon 011 was marked for identification.)

Q. BY MR. EVERETT: I'm going to hand to you now a document marked as IHC Deposition Exhibit 11. And I will represent to you that this is a printout of the first page of an Excel spreadsheet titled "final 95j" that was included on the CD ROM of maximum allowable fee schedules produced by IHC.

Do you recognize generally this document?

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A. Yes.

Q. I just have some questions about the meanings of some of the headings.

On the far left is a heading titled "CPT Code." Do you see that?

A. Yes.

Q. What does that mean?

A. CPT would be the procedure code or the HCPC code tied to that procedure code or tied to that -- that make sense?

Q. And what does "PCDDS," which is the heading of the next column, mean?

A. That is the description of that procedure code or that CPT code.

Q. The next column is headed "Count," and what is that intended to capture?

A. I am not familiar with that. I don't know if that's a count of codes billed or -- I don't know.

Q. The next column is headed "RVU." What does that stand for?

A. The RVU is a volume or work load factor.

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Q. And what does that mean?
A. And that would be used, as I understand it, in that reimbursement when we talked about the rider contract that said, you know, volume -- based on volumes you may be.
Q. I see. Next column is headed "1995 50%tile of Billed." And what does that mean?
A. That would be the 15th percentile of billed charges coming in.
Q. The next column is "1996 HC RVU Conv." Do you have an understanding of what that is intended to capture?
A. I don't know on that. I would assume it's a conversion based on their converting the RVU factor from 1995 over to 1996.
Q. The next two columns refer to "HC MAF." Am I correct in assuming that is intended to refer to IHC Health Plans maximum allowable fee?
A. Yes.
Q. And that would equate to allowed charges?
A. Yes.
Q. And then the last column is headed "1996

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HC % of Billed." What is that intended to capture?
A. That would reflect the percent off of billed that we will pay, or the percent of billed that we will pay.
Q. And how docs that relate to the allowed charge?
A. You will see either we have an allowed dollar amount, which if you go down those two columns you'll see the little zeros indicating that we haven't set a fixed dollar amount, and that instance then we will -- will be paying off a percent of billed.
Q. Okay. If the same -- the same terms appear in other fee schedules produced by IHC Health Plans but they have the same meaning --
A. Yes.
Q. -- in this document. Okay.
(Exhibit Cannon 012 was marked for identification.)
Q. BY MR. EVERETT: I'm going to hand you a document that's been marked as IHC Deposition Exhibit 12. And this is a printout of the first page of the Excel spreadsheet labeled "1999 MAF." Do you recognize this document?

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A. Yes.
Q. And is this a document that's kept in the ordinary course of IHC Health Plans' business?
A. Yes.
Q. All right. Again there are various headings at the top of the document, and I just have questions about the meanings of those headings. What does "MOD" in the second to left column mean?
A. I don't know.
Q. And the next column over says "Work RVU"?
A. All these RVU fields would be some volume adjustment.
Q. Mechanically do you know how those volume adjustments would affect the allowed charges that are identified elsewhere in the fee schedule?
A. No, I do not.
Q. What is the "HC Conversion Factor"?
A. HC would stand for Health Choice.
Q. Okay. And what is it converting?
A. I would imagine it's converting the old fee schedule from the year previous, but I can't comment.

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Q. There are different conversion factors for HC, IHC Care and SelectMed. Does that mean that there are different conversions -- conversion factors for IHC Health Plans' different products?
A. Yes.
Q. What is the difference between HC non facility MAF and HC facility MAF?
A. By facility I would assume we're talking about a hospital or infusion center. Non facility I would assume we're talking about a physician's office.
Q. Does IHC Health Plans reimburse for any services or products received by its members from providers that are not part of the IHC Health Plan network?
A. That depends on the product purchased by the employer. There are some products that require all services and procedures to be provided in panel, and in those instances there is one rate. There are some plans that we call plus plans, but they allow members to swing outside the network.
In those situations services are reimbursed at what we call standard benefits. So if